HOSPITAL DOCTORS: TRAINING FOR THE FUTURE

The Report of the Working Group on Specialist Medical Training

Supplementary Reports by the Working Groups Commissioned to Consider the Implications for General Medical Practice, Overseas Doctors and Academic and Research Medicine Arising from the Principal Report

NHS Executive
May 1995

FOREWORD

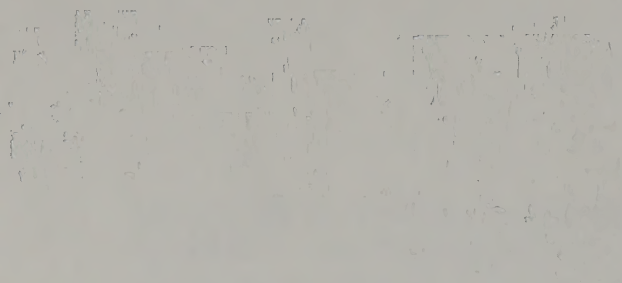
In December 1993 Ministers accepted the recommendations of the Report of the working group on specialist medical training *Hospital Doctors: Training for the Future*. The Report set out the principles to be taken into account in the planning of training programmes. It also recommended that a single training grade be established to replace the career and senior registrar grades and that a new Certificate of Completion of Specialist Training (CCST) be introduced which would meet the requirements of the EC Directives. The Report had been subject to consultation and its recommendations have been widely and warmly welcomed.

The Report, however, did not address the needs of three important groups of trainee doctors: overseas doctors; those wishing to pursue academic and research medicine; and those training in general practice. I was therefore pleased to convene three further working groups to give particular consideration to their needs. The work of the groups has been taken forward and I am now pleased to present their reports for consultation. Each reflects a careful analysis of complex and evolving training arrangements and makes recommendations which I believe will both clarify and advance the provisions for postgraduate medical education in the United Kingdom. Complementary work on implementing the principal Report has, of course, been taking place on other fronts, culminating recently in the issue of the report of the Unified Training Grade Working Party, which proposes specific arrangements for the introduction of a new specialist training grade, and a consultative paper on the legislative proposals necessary to comply fully with the EC Medical Directive and to implement several key recommendations of the principal Report.

In preparing these three further reports I acknowledge with pleasure and gratitude the help and co-operation I have received both from members of the working groups and from many others in tackling the challenging issues addressed in the reports.

Kenneth Calman
Chief Medical Officer

May 1995



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The Report of the Working Group on Specialist Medical Training

A Supplementary Report by the Working Group Commissioned to Consider the Implications for General Medical Practice Arising from the Principal Report

March 1995

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Summary of Recommendations

The Working Group recognises that some of the following recommendations may be taken forward in the short term, whereas others will need to be addressed in the longer term. As a guide only each recommendation has been marked either short term (*ST*) or long term (*LT*).

Recommendation: a: *The length of vocational training and the relative duration of the hospital and general practice components of training* (paras 8 - 21)

The Working Group recommends that:

i two phases of general practice training should be recognised: a period of vocational training and provision for a period of *higher/further training/education* which, until its value is widely accepted and resources can be secured, should remain voluntary; *(ST)*

ii the required competencies for both phases of training be defined and that core competencies be identified and regularly updated; *(ST)*

iii the attainment of core competencies in the period of vocational training in general practice should, pending an evaluation of programmes of *higher/further training/education*, be the minimum requirement for all trainees entering general practice; *(ST)*

iv flexibility in determining the balance of training experience obtained between hospital and general practice is required to take into account the needs of individual trainees and to reflect the most appropriate setting(s) for acquiring core competencies; *(LT)* and

v transfer of resources from secondary to primary care, to sustain an expansion of primary care services, should specifically include provision for an enhancement of training within primary care. *(LT)*

Recommendation b: *Assuring the educational quality of SHO posts* (paras 22 - 26)

The Working Group recommends:

i greater understanding of the relative values of the hospital and general practice components of vocational training together with better working relationships and planning at a local level between GP and hospital teachers; *(ST)*

ii improvements to the training programmes for all SHOs to mirror those being introduced for higher specialist training; *(LT)*

iii that the arrangements for approving and selecting SHO posts to meet the

requirements of the Vocational Training Regulations be reviewed; *(ST)*

iv that the General Medical Council, in making recommendations on general professional/basic specialist training, takes into account the requirements for training for general practice; *(ST)* and

v that, whilst acknowledging the administrative difficulties that will have to be addressed, and in line with greater flexibility in planning training, there is scope to vary the duration of hospital posts for vocational training. *(ST)*

Recommendation c: *Assessment methods for vocational trainees* (paras 27 - 29)

The Working Group commends the work undertaken in general practice by the Joint Committee on Postgraduate Training for General Practice, the Royal College of General Practitioners, the General Medical Services Committee, regional advisers in general practice and many others to develop further effective strategies for assessment of trainees. It recommends that:

i before entry to general practice, trainees should demonstrate competence in specified areas and to an agreed national standard; *(ST)* and

ii in line with European Directive 93/16/EEC, but subject to provisions for acquired rights, locums, deputies and assistants should be required to have relevant certification before undertaking NHS general practice. *(ST)*

Recommendation d: *Opportunities for experience in general practice for hospital trainees* (paras 30 - 31)

The Working Group recommends that opportunities for experience in general practice for those intent on a hospital career should be identified and the nature and potential benefits of such experience explored. *(LT)*

Recommendation e: *The contribution of academic general practice* (para 32)

The Working Group acknowledges the value of developing a coherent programme of education for general practice which addresses the continuum of undergraduate, postgraduate and continuing education. It recommends that, drawing upon the contribution of universities, opportunities for restructuring the present arrangements to provide improved and coherent links between the various phases of general practice education should be explored. *(LT)*

Recommendation f: *Career development for general practice educators* (para 33)

The Working Group recommends that the development of an integrated plan for the career development of both academic- and practice-based GP educators should be explored and build on the participation of academic- and practice-based general practitioners in all stages of general practice education. *(LT)*

Recommendation g: *Funding arrangements for vocational training* (paras 34 - 35)

The Working Group recommends that:

i provided provision for the trainer-trainee contract is not disturbed, and appropriate lines of managerial accountability are recognised, resources to enable the purchase of vocational training should be transferred from the general medical services budgets to the postgraduate dean's budget; *(ST)* and

ii regional advisers in general practice, working with postgraduate deans and in line with their purchasing role, should be empowered to purchase suitable training opportunities to deliver programmes of vocational training. *(ST)*

Introduction

1 At a time of great change for the National Health Service, general practice is presented with a number of important challenges in both service delivery and in education and training. Government led initiatives such as the white papers *Promoting Better Health*[1], *Working for Patients*[2] and *The Health of the Nation*[3] have highlighted the importance of health promotion and a more "managerial" approach to health care. The development of the internal market, including new NHS commissioning agencies and the introduction of fundholding practices, and the changing role of the general practitioner now, more than ever before, mean that the acknowledged high standards and professionalism of general practice training need to be enhanced yet further. It is essential that the effectiveness and relevance of the arrangements for delivering vocational training and continuing education are maintained.

2 It is clear that the changing role of the general practitioner and the consequential challenges in education and training need to be addressed. The impetus for this was provided by the Report of the Working Group on Specialist Medical Training *(The Calman Report)*[4].

Background

3 The *Calman Report* did not consider nor make recommendations on changes to the training of general practice. It was, however, recognised that further consideration of the implications of the Report's recommendations for general practice would be required.

4 The consultation exercise on the *Calman Report* identified the need for complementary arrangements for general practice postgraduate training and education to be considered. A primary concern arising from consultation was that changes proposed by the Report may adversely affect the hospital component of training and compromise the experience of new entrants to practice. GP trainees might find themselves disadvantaged by having to occupy what could be training posts with an unreasonably heavy service load. Some believed that this could happen where optimum training opportunities were reserved for doctors training in particular specialties. Further, if the delivery of training through shorter planned programmes,

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1 Promoting Better Health, The Department of Health, London, 1987

2 Working for Patients, The Department of Health, London, 1989.

3 The Health of the Nation, The Department of Health, London, 1992.

4 Hospital Doctors: Training for the Future, The Report of the Working Group on Specialist Medical Training, Department of Health, 1993.

increased the demand for training posts at present occupied by GP trainees, then their training could be compromised. Other specific points raised during the consultation process were that:

- there should be flexibility within the present arrangements for vocational training to enable an extension of the in-practice training component beyond one year; and

- consistent with the arrangements proposed for hospital specialist training, GP trainees, on satisfactorily completing training, should not, as is currently required, be denied opportunities for further training in general practice.

5 The Chief Medical Officer therefore convened a Working Group to address these and other issues. Its remit was:

> *"Following Ministerial approval of the Report of the Working Group on Specialist Training, to assess the impact of the Report's recommendations on general practice training and education; to identify what action is needed to safeguard and improve training opportunities and the standards of medical education and training in general practice; and to identify other professional and medical education and training issues in general practice which need to be addressed."*

6 The Working Group's task therefore was derived from an agenda which went beyond issues flowing directly from the Calman Report to include a range of wider general practice training issues. It took into account those matters that could be addressed in the short term and identified others that should be taken forward in the longer term and in light of further consideration. However, it was acknowledged that much useful work on many of the issues identified had already been undertaken by other bodies or was in progress (see Annex II). In fulfilling its remit the Group acknowledged the breadth of activity in the areas it considered and identified those in which further work would be required.

7 The overarching aim of the working group was to look ahead at the evolving role of general practitioners and the changing nature of their work and to ensure that the arrangements for vocational training continue to provide a sound foundation for general practice.

The length of vocational training and the relative duration of the hospital and general practice components of training

8 Currently the required minimum period of training within the United Kingdom is three years, consisting of two years ordinarily spent as an SHO on a planned or self-constructed rotational scheme in relevant hospital-based specialties, and a further year in a practice as a trainee. Successful completion of vocational training enables a trainee to be eligible to apply for appointment as a GP principal.

9 All doctors appreciate the challenge that keeping abreast of increasingly complex developments in their own and related disciplines presents. General practitioners are no different but, in addition to the requirement to maintain clinical competence, they must also adapt to the growth in primary care medicine in which their role will necessarily continue to evolve. It is therefore inevitable that the knowledge, skills and attitudes of tomorrow's practitioners will develop to reflect and accommodate these changes. The challenge is to ensure that new principals are equipped both to meet the demands of practice and to manage their personal needs for continuing education.

10 Given the changes outlined above, the present provisions for vocational training might no longer sufficiently equip inexperienced practitioners to assume fully the responsibilities of a principal in today's general practice. Two distinct but inter-related elements of vocational training are most frequently addressed: its duration and the relative balance of experience gained from the hospital and practice components.

The duration of training

11 Pressure to extend the conventional period of training is not new. Indeed a five year training programme for general practice was envisaged in the Report of the Royal Commission on Medical Education[5]. Many believe that such provision should now be introduced and be a requirement for appointment as a principal. It would complement the present period of vocational training with a two year period of *higher or further training or education*. Others, while not arguing specifically for two further training years or that such experience should be a prerequisite before appointment as a principal, strongly advocate opportunities for further education or higher training. Unquestionably there is a case for introducing arrangements for higher training or further education in general practice, although implementation must be subject to available resources.

12 Any changes to the present arrangements will, however, need to be seen within the context of the European Directive 93/16/EEC[6]. Within this Directive Title IV provides for specific training for general practice. In essence:

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5 The Royal Commission on Medical Education 1965-68, HMSO.

6 Council Directive 93/16/EEC of 5th April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualifications.....", Official Journal of the European Communities, Vol 36, July 1993.

- subject to the specific provisions for part time training, training in general practice should be a full time course lasting at least two years and supervised by the competent authority;

- training should be conducted as defined, there being a balance between theoretical and practical work; and

- Member States will be required to recognise each other's diplomas and permit the right to practice without further training from 1st January 1995.

The NHS Vocational Training Regulations already go beyond the minimum requirements of the Directive.

13 The period of *general professional training* is already the subject of much discussion. However, to effect such changes will not be easy and is likely to require modification to the regulatory framework. Further, as more teaching and learning time is involved, there will be additional costs. Were a change in the time required before the award of the UK certificate to permit practice as a principal to be mooted, then the implications for the recognition of equivalent diplomas and certificates of other Member States would have to be considered.

The balance of training experience obtained

14 Current arrangements for vocational training usually limit the training time in general practice to twelve months. Although quality rather than quantity is the most important aspect of training, for many trainees the balance between experience obtained in general and hospital practice may be inappropriate. This is particularly so given the changes in practitioners' work that now require development of a wider range of skills, an increased opportunity to develop new techniques for use in practice and the increasing role for primary care medicine. Indeed, some advocate that there should be a uniform change to the present arrangements requiring all trainees to spend eighteen months each in general and hospital practice. The Vocational Training Regulations[7] are not *per se* an impediment to altering this balance. However, they may not provide for a range of new community-based learning opportunities which trainees may find appropriate to their future career. Increased flexibility in the arrangements for vocational training is desirable: in particular the ability to vary the relative duration of the hospital and general practice components of the three year vocational training requirement to better meet the needs of individual trainees and of general practice.

15 Current funding arrangements, which effectively restrict the trainee's experience to one year of general practice, are seen as a particular limitation. The arrangements for funding training in the general medical services and in the hospital and community services are quite separate *(see paras 34 and 35)*: it is difficult to see how flexibility to alter this balance can be achieved without disturbing these arrangements. They are not a feature of the Vocational Training Regulations. There should, however, within

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[7] The NHS Vocational Training Regulations, SI No 1644, 1979, subsequent amendments and the corresponding arrangements for Northern Ireland and Scotland.

the Regulations be provision to recognise supervised experience relevant to general practice, which need not necessarily be obtained in a hospital specialty or in the specialty of public health (community) medicine, such as in commissioning or local authorities.

16 A change in the balance of experience during vocational training need not be equated with an increase in the duration of training. There may be cost implications but these are qualitatively different from those required to sustain an extension of training. A planned hospital rotation can, undoubtedly provide invaluable experience which will have to be balanced against the benefits a trainee might accrue from spending longer as a trainee or in some pertinent community-based activity. It may be that this balance has to be determined for and by the individual trainee.

17 A *first stage* in establishing the appropriate balance in GP training will be to define the core skills to be acquired by trainees. The Royal College of General Practitioners (RCGP) undertook such an exercise[8] in 1989, and given the changing nature of the GP's role the College is revising its definition. Indeed, any revised set of core competencies will inevitably require regular review. The GMSC is also currently examining the core content of general medical services.

18 A *second stage* will be the identification of the appropriate setting(s) for the development of training in each competency. Only after this had been achieved will it be possible to identify an appropriate balance between hospital- and practice-based training. Individuals' requirements for the successful acquisition of core competencies might vary (some will prefer the setting of general practice while others may wish, if possible, to master such competencies in hospital) and hence the capacity to vary the arrangements to meet individual needs will be desirable.

19 Acquisition of core competencies should therefore be achieved within the existing three year period of vocational training. However, it is clear that there will remain a range of additional or optional competencies that GPs might wish to acquire and which would not fall within the scope of core competencies. Consequently there will need to be a statement of the range of further skills or higher competencies which GPs might wish to attain, eg: additional clinical skills, competence in organisation and management practice, research methodology, epidemiology and proficiency in advanced teaching. Such skills could be acquired in the one or two years following first appointment as a principal. However, higher or further training will need to be introduced on a voluntary basis and will have to be funded in the short term from existing educational budgets.

20 In the longer term it may be possible to secure funding for these arrangements as part of the general transfer of resources from secondary to primary care which is already occurring and is likely to increase in the future.

21 The relationship between primary and secondary care is important. The Working Group notes that a single overarching advisory body for England and Wales is proposed to oversee medical workforce and education issues, supported by a

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[8] RCGP Working Group Paper "The Core of General Practice", 1989

simplified and streamlined advisory structure beneath it. It would cover general practice and public health issues as it is increasingly difficult to consider hospital medicine in isolation, both in terms of patterns of services and the numbers, training needs and skills of related staff.

a **The Working Group recommends that:**

i **two phases of general practice training should be recognised: a period of vocational training and provision for a period of *higher/further training/education* which, until its value is widely accepted and resources can be secured, should remain voluntary;**

ii **the required competencies for both phases of training be defined and that core competencies be identified and regularly updated;**

iii **the attainment of core competencies in the period of vocational training in general practice should, pending an evaluation of programmes of *higher/further training/education*, be the minimum requirement for all trainees entering general practice;**

iv **flexibility in determining the balance of training experience obtained between hospital and general practice is required to take into account the needs of individual trainees and to reflect the most appropriate setting(s) for acquiring core competencies; and**

v **transfer of resources from secondary to primary care, to sustain an expansion of primary care services, should specifically include provision for an enhancement of training within primary care.**

Assuring the educational quality of SHO posts

22 Concerns about the quality of training while trainees are SHOs are not new and, given that trainees spend more time in hospital than in general practice, improving the hospital experience is seen as a high priority. The Joint Committee on Postgraduate Training for General Practice (JCPTGP) has recently refined its policy for monitoring SHO posts. In some cases examples of failure to supervise training adequately, deficient strategies for assessing or monitoring progress and difficulties in delivering a credible educational programme have been identified. For many trainees service considerations override educational requirements and the "learning gap" is further compounded if the hospital experience bears little relevance to training for a career in general practice. In line with greater flexibility in planning training there is scope to vary the duration of hospital GP posts from the common practice of six month appointments, provided local administrative constraints can be accommodated. Further, it is important to invest in, and build on, the teaching skills of consultants to complement those of general practice trainers, course organisers and advisers.

23 Recent changes, brought in by the NHS Executive[9], introduced new flexibilities to the SHO establishment in England. These have reduced the risk that there could be a shortage of SHO training opportunities. Different arrangements apply elsewhere in the UK. However, guaranteeing the quality and relevance of the learning experience remains a formidable challenge. There are a number of ways in which training could be improved. Liaison between the RCGP and sister Royal Colleges has already resulted in guidance on how training in a number of specialties might be improved[10]. Planned or structured training programmes, as recommended by the *Calman Report*, could enable pertinent learning objectives and teaching methods to be identified and effective assessment strategies to be applied. It is therefore important that regional advisers are consulted before rotations of hospital posts are altered and are fully involved in the organisation of training.

24 Greater understanding of the relative values of the hospital and general practice components of vocational training together with better working relationships and planning at a local level between GP and hospital teachers is desirable.

25 Improving the process for selecting SHO posts to meet the requirements of general practice is a further strategy for enhancing the quality of training. The present selection process varies throughout the United Kingdom and is fully described in JCPTGP guidance[11]. In the light of the changes consequent on the recommendations of the *Calman Report*, the procedure is thought to be insufficiently rigorous. It merits review to ensure that "approved" posts specifically fulfil the requirements of the Vocational Training Regulations. While service interests must not be discounted trainees should not be placed in training positions which are judged inadequate. The commitment of hospital teachers and supervisors to deliver a credible and relevant training programme is vital.

26 The *Calman Report* recommended that "further consideration be given to the period of *general professional/basic specialist training*" and suggested that this be taken forward by the General Medical Council. The result of the Council's deliberations is not yet available, but whatever specific recommendations may be made, the *Calman Report* did recognise the need to provide for flexibility during this initial stage of specialist training - a period when the "doctor develops the wide range of general and basic specialist skills needed for more specialist practice". The Working Group would wish the General Medical Council to ensure that, in making recommendations on *general professional/basic specialist training*, the requirements for training for general practice are not compromised.

b The Working Group recommends:

i greater understanding of the relative values of the hospital and general practice components of vocational training together with better working relationships and planning at a local level between GP and hospital

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9 EL(94)17 The New Deal: plan for action

10 RCGP, series of booklets on the hospital component of vocational training, 1993.

11 JCPTGP; Accreditation of Regions and Schemes for Vocational Training in General Practice; 1992.

teachers;

ii **improvements to the training programmes for all SHOs to mirror those being introduced for higher specialist training;**

iii **that the arrangements for approving and selecting SHO posts to meet the requirements of the Vocational Training Regulations be reviewed;**

iv **that the General Medical Council, in making recommendations on general professional/basic specialist training, takes into account the requirements for training for general practice; and**

v **that, whilst acknowledging administrative difficulties that will have to be addressed and in line with greater flexibility in planning training, there is scope to vary the duration of hospital posts for vocational training.**

Assessment methods for vocational trainees

27 The *Calman Report* noted that "the process of assessment leading to the award of a CCST must be competency based, structured and interactive, with opportunities for discussion between the assessors and the individual being assessed. In particular regular assessment will be vital in ensuring that the appropriate standard for the award of a CCST can be reached, within a training period significantly shorter than that provided at present." The Report did not prescribe nor recommend specific schemes for assessment and recognised that individual Colleges would develop strategies of formative and summative assessment best suited to the needs of their particular curriculum. The Working Group agrees that a consistent national standard is required. It notes that the voluntary RCGP examination provides a national standard and that the JCPTGP is committed to introducing a new system of assessment, which accommodates assessment of competence and which employs a mix of different but complementary approaches. Given the complexity and importance of this issue the Working Group is not in a position to make detailed recommendations.

28 Strategies for assessing vocational training continue to evolve. In many ways general practice has been a leader in taking forward and developing assessment tools which are increasingly recognised as valid and reliable. The framework in which this occurs is not dissimilar to hospital practice where shortly a certifying procedure will mark the completion of specialist training in the same way that the present certification marks the completion of vocational training. In both cases the relationship and role of the relevant College examinations will increasingly be examined.

29 The Working Group notes that from 1st January 1995 all those undertaking general practice in Member States under their "national social security schemes", subject to acquired rights, will require the possession of a diploma, certificate or other evidence of formal qualifications to enable them to practise. The only given exception in the Directive being those undergoing specific training in general practice. The Working Group takes the view that such certification should also be required of locums, deputies and assistants. Further guidance is required to determine how the Directive will apply to doctors enrolled on the doctors' retainer scheme.

c **The Working Group commends the work undertaken in general practice by the Joint Committee on Postgraduate Training for General Practice, the Royal College of General Practitioners, the General Medical Services Committee, regional advisers in general practice and many others to develop further effective strategies for assessment of trainees. It recommends that:**

i **before entry to general practice, trainees should demonstrate competence in specified areas and to an agreed national standard; and**

ii **in line with European Directive 93/16/EEC but subject to provision for acquired rights, locums, deputies and assistants should be required to have relevant certification before undertaking NHS general practice.**

Opportunities for experience in general practice for hospital trainees

30 The Working Group considers that, within the period of *general professional/basic specialist training* (or indeed, if indicated during higher specialist training) opportunities for trainees pursuing a career in hospital to gain experience of and relevant training in general practice should be provided. The initial phase of specialist training - the period of *general professional/basic specialist training* - a time when, following basic medical education, trainees are able to develop a range of clinical competencies which form an invaluable foundation on which to base a career in hospital or general practice, is perhaps the optimum time to pursue such experience. The arrangements during this period are a matter on which the General Medical Council has been asked to make recommendations *(see para 26)*. Flexibility in training at this preliminary stage is desirable to enable those doctors, who so wish, to experience another specialty and to alter their career pathway. Longer term advantages would be that hospital consultants and teachers of the future with experience in general practice would be better able to understand the needs of vocational trainees, plan their training accordingly and should have a better understanding of patients' needs.

31 A number of practical issues need to be explored: what training and experience would be required; the length of the proposed practice experience; how it would be funded; and what level of experience should trainees expect to have to benefit from a period in general practice. The RCGP is undertaking work to define the skills and competencies that could be learned by trainees from other specialties.[12]

d **The Working Group recommends that opportunities for experience in general practice for those intent on a hospital career should be identified and the nature and potential benefits of such experience explored.**

The contribution of academic general practice

32 A sound relationship with universities is essential to ensure and enrich developments

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[12] RCGP; General Professional Training: Learning in General Practice for Future Hospital Specialists

in training for general practice. The case for strengthening and harnessing the contribution of academic general practice to postgraduate education and training and for a closer integration of university departments of general practice and the postgraduate education system for general practice has been made effectively[13]. It would facilitate links across the continuum of general practice education. The importance of securing legislative changes to enable pre-registration house officers more easily to obtain experience in general practice is supported.

e **The Working Group acknowledges the value of developing a coherent programme of education for general practice which addresses the continuum of undergraduate, postgraduate and continuing education. It recommends that, drawing upon the contribution of universities, opportunities for restructuring the present arrangements to provide improved and coherent links between the various phases of general practice education should be explored.**

Career development for general practice educators

33 The Working Group sees merit in a clear and complementary career structure for academic general practitioners and general practice educationalists. A working party of the Association of University Departments of General Practice had drawn attention to the opportunities that could follow from pursuing such a strategy[14]. It would permit not only effective career development within academic general practice but could enhance the career development of course organisers, GP tutors and regional and associate advisers. The importance of investing in "training the trainers" is recognised. Progress with such a strategy would require a number of practical and administrative problems to be overcome. It is vital that academic- and practice-based general practitioners develop closer links and that both contribute to training for general practice across the educational continuum.

f **The Working Group recommends that the development of an integrated plan for the career development of both academic- and practice-based GP educators should be explored and build on the participation of academic and practice-based general practitioners in all stages of general practice education.**

Funding arrangements for vocational training

34 The Working Group considered the suggestion that resources required for the funding of vocational training (for example trainees' salaries) should be part of the postgraduate dean's education budget, with the regional adviser as manager of such funds. However, to implement such a policy mechanisms would need to be introduced to ensure an appropriate allocation of funding for general practice training from within the dean's budget. This would mean a change in the present arrangements where such funding is drawn from FHSAs and Health Boards. In this way general

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[13] Allen J, Wilson A, Pereira Gray D J P, Fraser R; The Academic Base for General Practice: The Case for Change; BMJ, 307, 1993.

[14] AUDGP Working Party; A Career Structure for Academic General Practice;1993

practice would become wholly integrated within the developing arrangements for commissioning postgraduate education and more relevant and planned periods of training could be "purchased" by the regional adviser to meet the individual requirements of trainees.

35 Purchasing may also provide a means by which regional advisers working with postgraduate deans could pursue mechanisms for assuring the educational quality of SHO posts and of varying the relative duration of the general practice and hospital components of vocational training. It could also provide a vehicle, although not the funding, for facilitating the resourcing of trainees wishing to spend a short time in general practice while pursuing a hospital career. The strategy would therefore provide a significant mechanism for delivering greater flexibility in the provision of vocational training. Although more effective training could be anticipated the strategy would not in itself involve any additional new funds. Statements of required core competencies would be necessary to assist the purchasing function during the phase of vocational training in general practice. Likewise funding of higher or further training, which could be made available from commissioning agents, would also be facilitated if the competencies to be attained were defined.

g **The Working Group recommends that:**

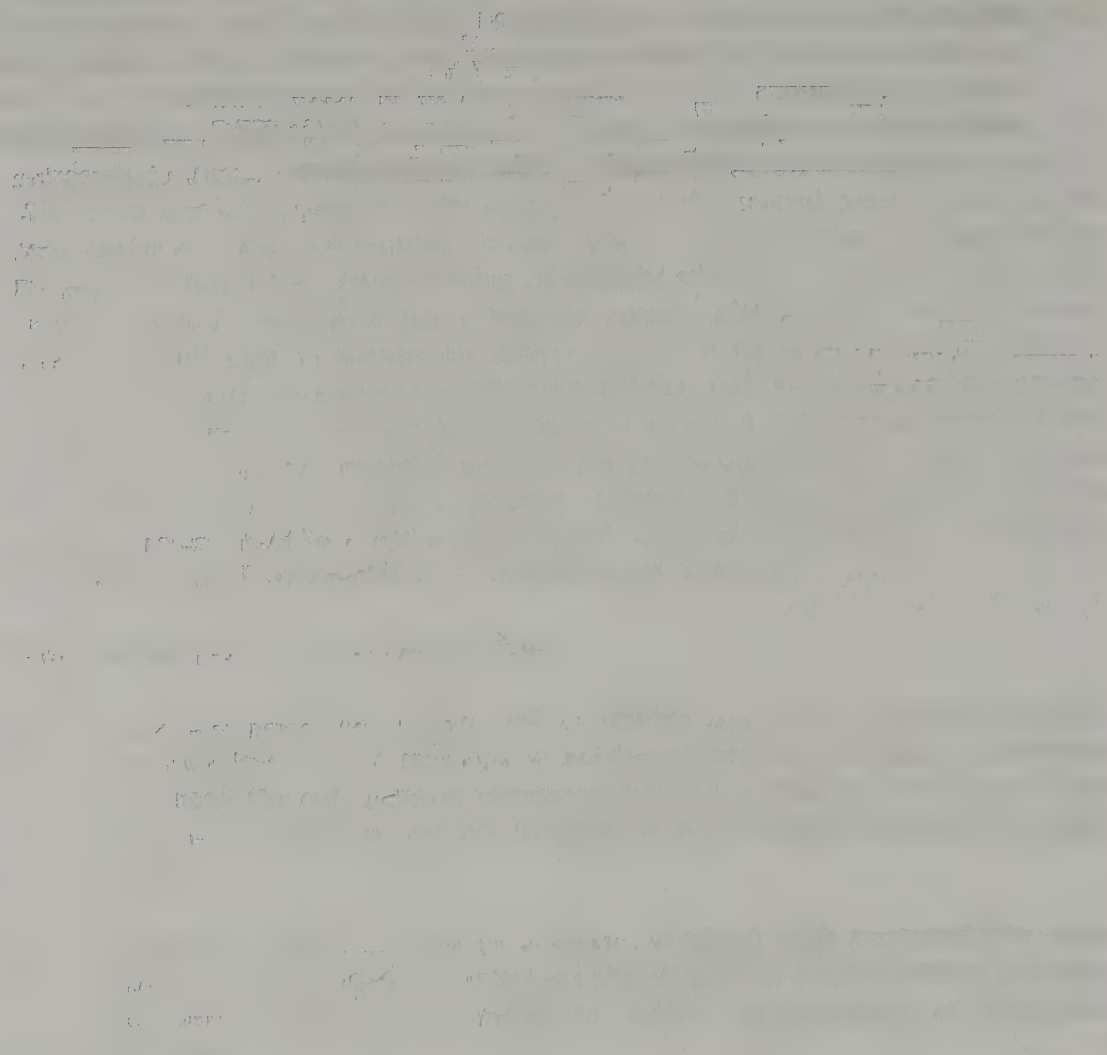
i **provided provision for the trainer-trainee contract is not disturbed and appropriate lines of managerial accountability are recognised, resources to enable the purchase of vocational training should be transferred from the general medical services budgets to the postgraduate dean's budget; and**

ii **regional advisers in general practice, working with postgraduate deans and in line with their purchasing role, should be empowered to purchase suitable training opportunities to deliver programmes of vocational training.**

Other Issues for Further Consideration

36 At present the JCPTGP is, in relation to Title IV of EC Directive 93/16/EEC, designated as the "competent authority" for general practice in the UK in respect of certification functions, while the The General Medical Council (GMC) is responsible for other functions such as attesting good character, physical and mental health and receiving declarations from visiting practitioners. For all other specialties the GMC is the competent authority. The Working Group acknowledges that, in view of changes in the arrangements for specialist medical training to comply with the EC Directive, the option of a single competent authority for medicine now merits consideration. It recognises, however, that it is not the forum in which such a strategy should be pursued.

37 The provisions for vocational training and entry into the general medical services as a principal are presently regulated by the NHS Act 1977, related Statutory Instruments and Health Service circulars. The Working Group recognises that there are implications for the present regulatory arrangements, including the Vocational Training Regulations, arising from certain of its recommendations and from the requirement to implement Title IV of Directive 93/16/EEC on general medical practice and that these will require further consideration.



Annex I

MEMBERSHIP OF THE WORKING GROUP

Chairman

Dr K Calman, Chief Medical Officer, Department of Health

Members

Dr J Allen, Honorary Joint Secretary, Joint Committee on Postgraduate Training for General Practice
Dr I Banks, Chairman, Trainees Sub-Committee, General Medical Services Committee
Dr T Bayley, Dean for Postgraduate Medical Education, The University of Liverpool
Professor R Fraser, Professor of General Practice, University of Leicester
Dr J Hayden, Regional Adviser in General Practice, North West Regional Office
Mr J Johnson, Joint Consultants Committee
Dr B Keighley, General Medical Services Committee
Dr W Reith, Honorary Secretary, Royal College of General Practitioners
Mr S Robbins, Chief Executive, Barnet Health Authority
Dr C Robinson, Chairman, National Association of Health Authorities and Trusts
Dr W Styles, Chairman of Council, Royal College of General Practitioners

Observers attending

Dr K Richmond, Welsh Office
Dr R Simmons, Scottish Office Home and Health Department

Secretariat provided by the NHS Executive

Dr R Cairncross
Dr A Cameron
Mr S Catling
Dr R Hangartner
Mrs P Haugh
Mr A Matthewman

Annex II

ADDITIONAL REFERENCES

1. Royal College of General Practitioners (1985). Quality and General Practice. Policy Statement 2. London, Royal College of General Practitioners.

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HOSPITAL DOCTORS: TRAINING FOR THE FUTURE

The Report of the Working Group on Specialist Medical Training

A Supplementary Report by the Working Group Commissioned to Consider the Implications for Overseas Doctors Arising from the Principal Report

March 1995

CONTENTS

Summary of Recommendations

The Working Group recognises that some of the following recommendations may be taken forward in the short term, whereas others will need to be addressed in the longer term. As a guide only each recommendation has been marked, where appropriate, either short term (*ST*) or long term (*LT*).

Recommendation a: *Background* (paras 3 - 22)

The Working Group endorses the policy that overseas doctors should have the right to fair and equal treatment in the NHS, in accordance with Government policies on equal opportunities for employment and, in England, within the framework set out in the NHS Executive booklet *"Ethnic Minority Staff in the NHS: A Programme of Action"* and recommends:

i high quality, relevant and structured training should be provided in order to attract those overseas doctors who will gain the most from planned training programmes and provide high standards of patient care both in the UK and on their return home *(ST)*;

ii other than for specific short-term purposes, overseas doctors should be appointed to training programmes and not to a series of separate training posts *(ST)*; and

iii with the introduction of revised training arrangements, including competitive entry to higher specialist training, the Health Departments should consider how the number of places on training programmes for overseas doctors may be determined *(ST)*.

Recommendation b: *Information required by overseas doctors* (paras 23 - 27)

The Working Group recommends, in the light of significant changes to training arrangements, the number of sources of information for overseas doctors and the difficulty in ensuring availability of relevant information especially abroad, that the information services for overseas doctors be better coordinated. In particular the Royal Colleges and the postgraduate deans should consider the development and publication of a national guide to NHS postgraduate training programmes that would complement the *"Guide to Postgraduate Degrees, Diplomas and Courses in Medicine" (LT)*.

Recommendation c: *Induction arrangements* (paras 28 - 32)

The Working Group recommends that:

i all overseas doctors should undertake, at the start of their training programme in the UK, an induction period of two - four weeks, based on educational need, to enable them to acclimatise to their new environment *(ST)*;

ii the postgraduate dean and the employer should share the costs of the induction period in line with current funding arrangements for the training grades *(ST)*;

iii the induction period should be planned, supervised, evaluated and, as far as practicable, tailored to individuals' needs *(ST)*;

iv the induction arrangements should be the responsibility of the postgraduate dean in association with the employer and the college adviser *(ST)*; and

v Royal Colleges and postgraduate deans should agree guidelines for the induction of overseas doctors in each specialty *(ST)*.

Recommendation d: *Common entry standards for English language and clinical competence* (paras 33 - 42)

The Working Group recommends, for overseas doctors entering specialist training, that the appropriate bodies *(indicated in brackets below)* review the arrangements for testing English and clinical competence, including the PLAB test, with the aim of accomplishing the following *(ST)*:

i all overseas doctors coming for training, without exception, pass a standard test of English competence before applying to the GMC for registration (GMC);

ii overseas doctors should be able to attempt the English language component of the PLAB test or an acceptable equivalent in the UK or abroad (GMC/PLAB);

iii entry to the clinical component of the PLAB test should require demonstration of an acceptable level of competence in the English language component of the PLAB test or an acceptable equivalent (GMC/PLAB);

iv all overseas doctors wishing to enter *general professional/basic specialist training* should be required to pass the clinical component of the PLAB test (GMC); and

v satisfactory methods of assessing clinical competence should be introduced to enable overseas doctors entering the unified training grade to demonstrate a comparable level of competence to UK doctors (UK Royal Colleges and their Faculties).

Recommendation e: *Monitoring trainees' progress: the role of a numbering system* (paras 43 - 44)

The Working Group recommends:

i a numbering system for overseas doctors in the unified training grade be introduced to parallel the National Training Number granted to UK/EEA doctors *(ST)*; and

ii the system be extended, if practicable, to cover overseas doctors in the SHO grade *(LT)*.

Recommendation f: *Structured training and entry points to training* (paras 45 - 47)

The Working Group recommends that:

i overseas doctors must be integrated with UK doctors into structured training programmes in the SHO and unified training grades with training being tailored as far as is practicable to meet their needs *(ST)*; and

ii while overseas doctors may move between *general professional/basic specialist training* and *higher specialist training* they must meet the same or equivalent standards for entry to *higher specialist training* programmes and to the unified training grade as is required of United Kingdom and European Economic Area nationals *(ST)*.

Recommendation g: *Locum experience* (paras 48 - 51)

The Working Group recommends that:

i vacant positions on training programmes, normally filled by locum appointments, which could provide valid training for part of an individuals' planned training programme and which are educationally approved, should be named "*fixed-term training appointments*" and not referred to as locum appointments *(ST)*;

ii a planned training programme cannot be largely or solely based on such "*fixed-term training appointments*" *(ST)*; and

iii other than "*fixed-term training appointments*", locum appointments cannot be regarded as providing acceptable training *(ST)*.

Recommendation h: *Immigration Arrangements* (paras 52 - 54)

The Working Group recommends that consideration be given to reviewing the immigration arrangements for overseas doctors (including the provision for discretionary extension of permit-free status) taking account of the changes in training arrangements proposed in the *Calman Report* and in this Report *(ST)*.

Recommendation i: *Implications arising from the introduction of EC Directive 93/16/EEC* (paras 56 - 63)

The Working Group notes that overseas doctors, who meet the necessary requirements and have successfully completed a specialist training programme, may be eligible for the award of a CCST by the GMC on the advice of the relevant Royal College or Faculty. It recommends that the advice of Royal Colleges and Faculties to the GMC on a doctor's training and competence should take account of training experience gained abroad, where the quality of such training can be confirmed *(ST)*.

Recommendation j: *Coordinating the training arrangements for overseas doctors* (paras 64 - 68)

The Working Group recommends that:

i the arrangements for delivering training to overseas doctors be coordinated, monitored and evaluated and that the various parties concerned work in partnership; (*LT*) and

ii postgraduate deans should identify a member of staff: to assume responsibility or take a special interest in issues of relevance to overseas doctors; to monitor their progress; to advise on their individual training needs; and to liaise with others who have particular responsibility for supervising their training *(ST)*.

Recommendation k: *Arrangements for sponsorship including the Overseas Doctors Training Scheme* (paras 69 - 73)

The Working Group recommends, in the light of proposed changes to the training arrangements within the United Kingdom and its recommendation requiring demonstration of a satisfactory standard of English and clinical competence, that the arrangements for sponsoring overseas doctors for training in the UK, including the ODTS, should be reviewed by the Health Departments (*ST*).

Introduction

1. A significant number of doctors who staff the National Health Service (NHS) were born and trained outside the United Kingdom (UK). This is particularly true of the training grades where many doctors who have no right of residence in the United Kingdom are able to undertake a limited period of postgraduate training.

2. The standards of training of overseas doctors and the contribution they make to the successful operation of the NHS are important. The Report of the Working Group on Specialist Medical Training (*The Calman Report*[1]) has far reaching implications for the delivery of specialist training in the United Kingdom. Inevitably there are implications for overseas doctors and the manner in which they are trained. A review of the arrangements for their training is therefore both timely and essential.

Background

3. The *Calman Report* did not address the particular requirements of doctors from overseas. It was, however, recognised that further consideration of the implications of the Report's recommendations for the training of overseas doctors would be required.

4. The Chief Medical Officer therefore convened a Working Group with the following terms of reference:

> *"To review the arrangements, including funding, for the training of all overseas doctors coming to the UK for postgraduate training within the NHS taking into account:*
>
> - *the implications of the Report of the Working Group on Specialist Training;*
>
> - *the need to ensure that overseas doctors are able to make an appropriate service contribution, within structured training programmes, to assist the reduction in junior doctors hours; and*
>
> - *current immigration arrangements.*
>
> *and to make recommendations to the Secretary of State, including areas requiring further action."*

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[1] Hospital Doctors: Training for the Future, The Report of the Working Group on Specialist Medical Training, Department of Health 1993.

5. The Working Group's task therefore extended beyond issues flowing directly from the *Calman Report* and, in preparing its recommendations, it took account of those matters which could be addressed in the short term, and identified others which should be taken forward in the longer term and in the light of further consideration.

6. The overarching aim of the Working Group was to ensure that the arrangements for overseas doctors' training are compatible with the principles for planned education and training espoused in the *Calman Report*.

Who is an overseas doctor?

7. For the purpose of this Report and unless otherwise indicated, an overseas doctor is a doctor who, regardless of where he or she obtained their primary medical qualification, does not have a right of indefinite residence in the UK as determined by immigration and nationality law, or who does not benefit from European Community (EC) rights. EC nationals have the right to establishment and free movement throughout the EC and are not, therefore, included in this definition of overseas doctors and do not come within the scope of this report. Since 1 January the EC provisions on training and mutual recognition for doctors have also applied in certain EFTA countries (Austria, Norway, Sweden, Finland and Iceland) which together with the EC member states and Liechtenstein constitute the European Economic Area (EEA). **For simplicity and convenience this paper refers throughout to the EEA**. The provisions will also be extended to Liechtenstein when the EEA agreement comes into force in relation to that country. Since 1 January 1995, Austria, Sweden and Finland have become members of the EC.

Discrimination

8. It is important to state that there is no place for discrimination on grounds of either race or sex. The NHS and the Health Departments are already undertaking significant work in promoting and implementing equal opportunities policies, mainly via the framework set out in the NHS Executive booklet "Ethnic Minority Staff in the NHS: A Programme of Action"[2]. Therefore, although equality of opportunity is recognised as an important issue it is not judged appropriate to address it specifically within this Report.

Training in General Practice

9. There are very limited circumstances under which overseas doctors may pursue training in general medical practice. Hence almost all overseas doctors must undertake training in hospital services.

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[2] Ethnic Minority Staff in the NHS: A Programme of Action, NHS Executive, Department of Health: 1993.

The new arrangements for specialist training

10. The *Calman Report* defined *specialist training* as that period between full registration and the award of the Certificate of Completion of Specialist Training *(CCST)*. It is frequently regarded as comprising two distinct but linked phases:

- *general professional/basic specialist training* (*GPT/BST*) - the first phase of specialist training leading to higher specialist training; and
- *higher specialist training* (*HST*).

11. A new *unified training grade* (*UTG*)[3] is planned. Through it *higher specialist training* will be delivered while *basic specialist or general professional training* will be provided for by the SHO grade. The interface between the two phases - including entry requirements to the *UTG* - is being considered by a Working Party convened to examine the arrangements for the introduction and operation of the new grade.

12. Key features of both phases of specialist training will include:

- explicit educational and service entry requirements for admission to training programmes and in particular to higher specialist training;
- competitive entry to training programmes;
- for most specialties, a shorter duration of training;
- more intensive training which is both managed/directed and supervised;
- progress dependent on educational attainment; and
- graded service responsibility as the trainee progresses through training.

13. Future arrangements for delivering training may, therefore, be based on three premises. First, in a more structured, better planned and often shorter training period it is impractical to retain three training grades. Second, the three present grades are no longer seen as meaningful - they do not reflect the stages of training reached by trainees and can delay training progression due to lack of career opportunity. Third, a proper balance between education/training and service requirements is necessary.

14. The new unified grade will in essence be synonymous with higher specialist training. It has, therefore, to be seen in context - in particular how it relates to basic medical education, the initial phase of *basic specialist/general professional training* and to the award of the CCST.

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[3] This is the temporary title for this proposed new grade

Why do overseas doctors come to the United Kingdom?

15. The tradition of overseas students and doctors coming to the UK to study both undergraduate and postgraduate medicine is long established and has made a major contribution to the health services of both developed and developing countries. Generally, overseas doctors wish to avail themselves of the quality and breadth of training they can receive in the UK. More specifically they have particular aims or goals that they wish to attain including training, for example, towards acquiring a Royal College diploma or gaining specific short-term experience at higher specialist level. In addition the provisions of the *work permit scheme* enable the employment in the career grades of a number of overseas doctors.

Why does the United Kingdom wish to attract overseas doctors?

16. The first report of the *Medical Manpower Standing Advisory Committee (MMSAC)*[4], whose recommendations were accepted by the Secretary of State, confirmed the principal of self-sufficiency in medical manpower supply for the UK. The report commented:

> *"Self-sufficiency does not necessarily mean planning for all UK posts to be filled by UK doctors. Rather, that sufficient UK doctors should be trained so that all UK demand could be met if the flow of UK doctors to other countries was balanced by the flow of EC and overseas doctors to the UK."*

17. It is not part of the Working Group's remit to consider or make recommendations on the numbers of overseas doctors in training. Nevertheless, the introduction of revised training arrangements, including competitive entry to *HST*, brings with it implications for the number and kind of training opportunities available. In England and Wales the proposed new NHS Executive Advisory Group on Medical Education, Training and Staffing should consider how the number of places on training programmes available for overseas doctors should be determined. Separate arrangements apply in Scotland and Northern Ireland.

18. There are several reasons why the UK wishes to attract overseas doctors for training:

- the mix of cultures and races, with the varied contribution that each brings, enhances the training experience for all doctors;
- they make an important and necessary contribution to service provision (as is provided by all doctors in training);
- to improve health care abroad; and

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[4] Planning the Medical Workforce, Medical Manpower Standing Advisory Committee: First Report, Department of Health, 1992.

- there are benefits for cultural and diplomatic links which in the long-term facilitate improved international exchange.

19. It is most important that overseas doctors do not remain in the UK otherwise their "home countries", which have invested in their education, will be deprived of their skills and may be unable to attract replacement medical staff. The Immigration Rules are clearly framed to prevent this from happening. They provide that *permit-free* status for postgraduate training is only granted under the Immigration Rules where the individual can satisfy the Home Office that he/she intends to return home on completion of either their training or the period for which *permit-free* status is granted, whichever is first. This arrangement does not preclude some *permit-free* trainees gaining *settled status* through other immigration arrangements.

Attracting overseas doctors to the United Kingdom

20. The UK should aim to attract those overseas doctors who will gain the most from planned training programmes and who will provide high standards of patient care both in the UK and on their return home. However, this aim is only likely to be achieved if these doctors have access to high quality, relevant and structured training. A key step to achieving this will be to ensure that overseas doctors are appointed to training programmes and not to a series of separate training posts. This will facilitate the delivery of planned and structured training.

21. There is increasing evidence, in part anecdotal, to suggest that other countries, for example the USA and Canada, where doctors may more readily complete a recognised programme of postgraduate training, are attracting overseas doctors who might once have come to the UK. It is also acknowledged that the number of overseas doctors seeking to train in the UK may reduce as training facilities in the developing world improve. However, demand for training opportunities in the UK currently remains high.

How many overseas doctors in postgraduate training are there?

22. The numbers of overseas[5] doctors coming to the UK for training is substantial and since at least 1988 has been increasing steadily. In the UK in 1992 approximately 25% of SHOs, 36% of Registrars and 12% of Senior Registrars had primary qualifications obtained outside the European Economic Area. Overall this amounted to 26% of the UK workforce in the three training grades.

a **The Working Group endorses the policy that overseas doctors should have the right to fair and equal treatment in the NHS, in accordance with Government policies on equal opportunities for employment and, in England, within the**

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[5] In this context "overseas" means country of qualification outside the UK and EC with place of birth applied as a proxy when country of qualification is not available.

framework set out in the NHS Executive booklet *"Ethnic Minority Staff in the NHS: A Programme of Action"* and recommends:

i **high quality, relevant and structured training should be provided in order to attract those overseas doctors who will gain the most from planned training programmes and provide high standards of patient care both in the UK and on their return home;**

ii **other than training provided for specific short-term purposes, overseas doctors should be appointed to training programmes and not to a series of separate training posts; and**

iii **with the introduction of revised training arrangements, including competitive entry to higher specialist training, the Health Departments should consider how the number of places on training programmes for overseas doctors may be determined.**

Key Issues Pertinent to the Training of Overseas Doctors

23. The key issues identified in this Report are discussed in a chronological sequence: from the time when an overseas doctor considers coming to the UK for training to the completion of specialist training. Sponsorship arrangements, which have relevance to several parts of the Report, are dealt with at the end. There are three themes that the recommendations of the Report reflect:

- quality;
- flexibility; and
- simplicity

of training arrangements.

Information required by overseas doctors

24. Before overseas doctors make a commitment to come to the UK for postgraduate training it is important that they are well informed about relevant issues such as registration requirements, training opportunities, remuneration and immigration arrangements. Without such information doctors can make incorrect assumptions about the length, content and availability of training, which may in turn adversely affect their training experience in the UK. This is in no one's interest.

25. There are a variety of sources of information and advice for overseas doctors including Government Departments, the General Medical Council (*GMC*), the British Medical Association *(BMA)* and individual medical Royal Colleges. Two important and comprehensive sources of information are:

i *The National Advice Centre for Postgraduate Medical Education* (NACPME) operated by the British Council since 1989. Approximately 30 written and telephone enquiries are received a day and a senior medical officer provides an advisory service to personal callers on one day a week in London. Other services are a medical information pack for which frequent updates are issued, a regular newsletter and involvement in the annual production of the *Guide to Postgraduate Degrees, Diplomas and Courses in Medicine*[6]. Funding for NACPME is mainly provided by the Department of Health, although many enquiries are handled by the British Council's overseas offices for which no financial support is provided by the Department. NACPME does, however, provide a support service for the overseas offices.

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[6] Guide to Postgraduate Degrees, Diplomas and Courses in Medicine. IntelliGene in association with the National Advice Centre for Postgraduate Medical Education: 1994

ii *The Overseas Doctors' Association - Welfare, Information and Advisory Service* (WIAS). This service accepts enquiries from overseas doctors whether they are members of the ODA or not. Approximately 20 - 30 enquiries are taken a day. Most are about the Overseas Doctors Training Scheme (ODTS), the PLAB (Professional and Linguistic Assessments Board) test and registration with the GMC, although discipline and other matters are also raised. The WIAS has received a grant from the Department of Health since 1979.

26. There are advantages if information for overseas doctors could be comprehensive and readily available both overseas and in the UK. Existing information services should be enhanced, particularly those which offer access before a doctor comes to the UK. Better information is required about postgraduate training programmes in the NHS, perhaps similar to the information readily available in the United States in the "*The Graduate Medical Education Directory*"[7], often referred to as the "Green Book". Any guide to training programmes in the NHS should be a national one and complement the "*Guide to Postgraduate Degrees, Diplomas and Courses in Medicine*".

27. The Health Departments will issue new simplified guidance on the employment of overseas doctors and dentists in the National Health Service.

b **The Working Group recommends, in the light of significant changes to training arrangements, the number of sources of information for overseas doctors and the difficulty in ensuring availability of relevant information especially abroad, that the information services for overseas doctors be better coordinated. In particular the Royal Colleges and the postgraduate deans should consider the development and publication of a national guide to NHS postgraduate training programmes that would complement the *"Guide to Postgraduate Degrees, Diplomas and Courses in Medicine"*.**

Induction arrangements

28. Many overseas doctors are unfamiliar with their surroundings when they enter the UK. There will often be differences of culture, language and clinical practice. In some cases doctors are simply not suited to training in the specialty they have chosen. This can lead to poor performance in training and/or valuable training resources being wasted. These difficulties can, in part, be alleviated by full advantage being taken of the information services outlined above and counselling where necessary. A period of induction included at the start of first employment would further improve the chances of overseas doctors achieving a full and satisfactory training experience. A number of Royal Colleges already provide induction courses. Experience suggests

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[7] The Graduate Medical Education Directory: The American Medical Association, Chicago, Illinois, USA.

that those doctors who have undertaken an induction programme have found it invaluable.

29. An induction period has not normally been readily funded. In some situations employers have made a loan available to the doctor to meet the cost of an induction period of say one month. This was then repaid by the doctor from his subsequent salary payments. Alternative options could be for the employer to fund the period directly, thus showing commitment to the trainee, or for the postgraduate dean to assume partial or full responsibility for funding. It is considered that the induction period should be fully salaried as is the case with induction periods in other types of employment. If trusts were to provide funding this would mean a disproportionate cost on the trust where the doctor started his/her training programme. There are therefore advantages if the postgraduate dean and the employer share the costs in line with current arrangements for funding of the training grades. In Scotland different arrangements may need to be developed in view of the different funding mechanisms

30. Any induction period would have to be included as part of the *permit-free* training period to comply with the Immigration Rules and should, therefore, form part of the employment contract.

31. An induction period may include a probationary function whereby the employer or training supervisor are able to assess a doctor's suitability for continuing training and service responsibility. Equally trainees can get used to their new environment and be sure that they will be suited to it. Employers will normally have made an initial assessment at the interview stage of the suitability of a doctor for the service and training commitments of the post on offer. Hence, an induction period may form a useful part of any probationary arrangements.

32. The induction period needs to be planned, supervised and evaluated if it is to fulfil its potential.

c **The Working Group recommends that:**

i **all overseas doctors should undertake, at the start of their training programme in the UK, an induction period of two - four weeks, based on educational need, to enable them to acclimatise to their new environment;**

ii **the postgraduate dean and the employer should share the costs of the induction period in line with current funding arrangements for the training grades;**

iii **the induction period should be planned, supervised, evaluated and, as far as practicable, tailored to individuals' needs;**

iv **the induction arrangements should be the responsibility of the postgraduate dean in association with the employer and the college adviser; and**

v **Royal Colleges and postgraduate deans should agree guidelines for the induction of overseas doctors in each specialty.**

Common entry standards for English language and clinical competence

33. A common standard, which all overseas doctors coming to the UK for postgraduate training should attain, is in principle considered desirable. It has the advantages of equity (not only between overseas doctors but also with UK/EEA doctors), of simplicity (a contrast to the present complex arrangements) and of ensuring that entry standards can be assured. Currently there are several access routes for overseas doctors embarking on postgraduate training. For instance, some overseas doctors must pass the PLAB test but some are exempt; some obtain limited registration with the GMC but others have full registration; some are sponsored by Royal Colleges (either through double-sponsorship or the ODTS) but the majority are not; and some are required to take an English test while others are not.

34. If overseas doctors are required to attain a common standard in English, and possibly clinical competence, a common minimum standard, which all overseas doctors wishing to train in the UK had to meet, would be realised. This would be in the interests of both patients and overseas doctors who will wish to be assured that they will benefit from costly and intensive, structured training programmes.

English language competence

35. Overseas doctors arrive in the UK with varying checks made on their fluency in English. Before the GMC can grant *limited registration*[8] it must satisfy itself that, amongst other things, the person has "the necessary knowledge of English"[9]. Therefore, most overseas doctors have to pass the GMC's PLAB test which contains two principal elements: a test of English competence and a test of clinical competence. A number of overseas doctors are exempt from the PLAB test by virtue of:

- *general exemption.* This may apply to doctors who have qualified at certain overseas universities in, for example, Australia, Hong Kong etc.

- *restricted exemption.* This may be granted on the basis of sponsorship, e.g. through a Royal College ODTS, and enables selected doctors to be placed in approved supervised appointments for training within a specific specialty. It can also apply to doctors who, in addition to their overseas qualification, also hold a higher medical qualification awarded by a Royal College or Faculty in the UK or Republic of Ireland which is registerable with the GMC.

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8 The process of registration (whether full or limited) which depends on the place of qualification, is independent of that which determines immigration status.

9 Section 22, Medical Act 1983

- *eligibility for full registration.*

36. Competence in English is a major influence on a doctor's training progress, performance in examinations and ability to provide satisfactory patient care. In the United States and Canada language testing is compulsory for all overseas doctors. It is questionable whether the privilege of sponsorship, either by or through a Royal College, should lead to exemption from some form of common entry procedure for linguistic competence. Indeed some Royal Colleges already require their sponsored doctors to take the International English Language Testing Service (IELTS) examination.

37. In its current form the IELTS examination could not be substituted for the English component of PLAB. It can, however, be taken in many centres overseas. Currently the PLAB test is only held in the UK and in 1992 of 2,144 attempts at the PLAB test, 69% resulted in failure. If all overseas doctors, including those in sponsorship and those eligible for full registration, were required to pass the English component of the PLAB test, the numbers of overseas doctors required to take PLAB could increase significantly, perhaps by as much as 100% (1,845 overseas doctors gained exemption from PLAB in 1993).

38. It is clear, therefore, that many overseas doctors who have no likelihood of passing PLAB travel to the UK unnecessarily to take the examination and in the process incur significant costs. There is merit in the GMC and the PLAB considering whether it would be possible to screen out those doctors who had little chance of completing the PLAB test before they came to the UK. One method could be to alter the existing arrangements for the PLAB test to allow the English component, or an acceptable equivalent, to be taken at a number of suitable centres abroad as well as in the UK.

Clinical competence

39. The current checks on standards of clinical competence at the time of recruitment such as appointment procedures, the PLAB test, the ODTS and other sponsorship schemes are not always understood to be sufficiently effective or appropriate. A test of clinical competence for all overseas doctors entering the UK to practise should be considered. However, with different points of entry to postgraduate training, at *GPT/BST* and *HST*, and consequently different levels of competence and experience to be assessed, there are potential difficulties if all overseas doctors were required to take the same test of clinical competence.

40. The PLAB test currently assesses whether a doctor is competent to practise at SHO level, normally someone who has qualified in the previous two to four years. Of the 5,790 overseas[10] qualified doctors in the training grades in England in 1992, 5,300 were either SHOs or registrars. The introduction of separate *GPT/BST* and *HST* programmes, coupled with the commitment to flexible entry to training schemes *(see paragraph 45)*, will mean that overseas doctors will have the opportunity to enter the

[10] See footnote 5.

UK, at a level equivalent to the registrar and senior registrar grades or the proposed unified training grade, i.e. at a point further away from their original qualifying date than the PLAB test currently targets. To meet these new circumstances the present approach to assessing clinical competence should be reviewed.

41. For entry to *GPT/BST* all overseas doctors should pass the clinical component of the PLAB test. However, such an assessment may well be unsuited to those embarking on *HST* for whom a general test, such as PLAB, might not be appropriate. Validated tests of clinical competence for each specialty could be devised but this would be a formidable and impractical exercise. A more satisfactory method is required to allow overseas doctors entering the *UTG* to demonstrate a comparable level of competence to UK doctors. This could be realised by overseas doctors meeting the entry requirements to the grade as defined by the relevant Royal College or Faculty or, in certain circumstances to be defined, could be dependant on an independent assessment by the relevant Royal College.

42. The following recommendations will have implications for sponsorship arrangements. These are discussed further under the section entitled "*Arrangements for Sponsorship including the Overseas Doctors Training Scheme*" (paras 69 - 73).

d The Working Group recommends, for overseas doctors entering specialist training, that the appropriate bodies *(indicated in brackets below)* review the arrangements for testing English and clinical competence, including the PLAB test, with the aim of accomplishing the following:

i all overseas doctors coming for training, without exception, pass a standard test of English competence before applying to the GMC for registration (GMC);

ii overseas doctors should be able to attempt the English language component of the PLAB test or an acceptable equivalent in the UK or abroad (GMC/PLAB);

iii entry to the clinical component of the PLAB test should require demonstration of an acceptable level of competence in the English language component of the PLAB test or an acceptable equivalent (GMC/PLAB);

iv all overseas doctors wishing to enter *general professional/basic specialist training* should be required to pass the clinical component of the PLAB test (GMC); and

v satisfactory methods of assessing clinical competence should be introduced to enable overseas doctors entering the unified training grade to demonstrate a comparable level of competence to UK doctors (UK Royal Colleges and their Faculties).

Monitoring trainees' progress: the role of a numbering system

43. All UK/EEA nationals who gain a place on a unified training grade training programme will be awarded a National Training Number (NTN) by the appropriate postgraduate dean. The NTN Implementation Steering Committee (NTNISC) has recommended that there should be a separate but parallel system for overseas doctors in higher specialist training. Numbers under this system could be called Visiting Training Numbers (VTNs) and would be distinguished from NTNs for UK/EEA nationals by the suffix /V.

44. A numbering system to monitor overseas doctors training is essential and would support the introduction of structured training. A system, in line with that recommended by the NTNISC, should be put in place. At present plans for a numbering system are limited to the unified training grade. However, because overseas doctors are more likely to have unplanned training experiences, it would be desirable to extend the numbering system suggested for the *UTG* to include the SHO grade.

e **The Working Group recommends that:**

i **a numbering system for overseas doctors in the unified training grade be introduced to parallel the National Training Number granted to UK/EEA doctors; and**

ii **the system be extended, if practicable, to cover overseas doctors in the SHO grade.**

Structured training and entry points to training

45. Overseas doctors come to the UK for differing reasons, have differing needs, and differing degrees of training and experience before they arrive. It is important to recognise and accommodate these differences and, where relevant, to provide flexible entry points to training programmes. Royal Colleges have an important role in advising how experience and training gained abroad should influence the level of entry to training programmes.

46. Overseas doctors must be integrated into structured training programmes in the SHO and unified training grades with the training being tailored, as far as is practicable, to meet their needs when returning to their home countries.

47. Overseas doctors should be able to move from *GPT/BST* to *HST*. It is, however, important to note that there is a barrier between *GPT/BST* and *HST* which is governed by strict entry requirements. There is no justification for exempting overseas doctors from any or all of these requirements. Indeed, if they wish to be eligible for the award of a CCST *(see para 56 et seq)* it is essential that, while they may not necessarily compete with UK doctors for a place in the *UTG*, they meet the same or equivalent standards for entry to the grade as those required of UK/EEA doctors.

f **The Working Group recommends that:**

i **overseas doctors must be integrated with UK doctors into structured training programmes in the SHO and unified training grades with training being tailored as far as is practicable to meet their needs; and**

ii **while overseas doctors may move between *general professional/basic specialist training* and *higher specialist training* they must meet the same or equivalent standards for entry to *higher specialist training* programmes and to the unified training grade as is required of United Kingdom and European Economic Area nationals.**

Locum experience

48. Many overseas doctors in the UK undertake locum appointments in training grade posts. Often such appointments consist solely of meeting service requirements or the teaching provision is limited or not relevant to the doctors' needs. Many overseas doctors are understood to undertake a series of such posts. The inevitable result of this is that there is little "training" to speak of and certainly no structured or planned training experience. This unsatisfactory state of affairs often results in these doctors becoming dissatisfied with their experience in the UK and in a loss of job satisfaction which, in some cases, may manifest itself in lower than desired standards of patient care. This is detrimental for all concerned.

49. Locum is a term that is generally identified with meeting a service need. Although this is true of the majority of locum appointments not all should be viewed in this way. There may be some benefit in identifying posts which will become temporarily vacant in training rotations (perhaps because the incumbent is on maternity leave or pursuing research) and using them flexibly to accommodate overseas doctors who, as part of individuals' planned training programmes, would benefit from the training provided in such posts. Rather than calling such posts locum posts, an alternative title, such as *"fixed-term training appointments"* would be more appropriate.

50. A planned training programme could not be largely or solely based on *fixed-term training appointments*. Further, such appointments could not be retrospectively identified as recognised for training. The National Post/Programme Numbering system[11] (NPN) should identify posts which have been approved for training thus helping to ensure that non-numbered posts did not feature in a doctor's postgraduate training experience.

51. A Working Group has been looking at issues surrounding the quality of locum doctors. Its Report has been published for consultation. One issue it considered was

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[11] The National Post/Programme Numbering System (NPN) will be closely linked to the National Training Number System (NTN).

the quality of training provided in locum posts and its recommendations are broadly compatible with those made here.

g **The Working Group recommends that:**

i **vacant positions on training programmes, normally filled by locum appointments, which could provide valid training for part of an individuals' planned training programme and which are educationally approved, should be named "*fixed-term training appointments*" and not referred to as locum appointments;**

ii **a planned training programme cannot be largely or solely based on such "*fixed-term training appointments*"; and**

iii **other than "*fixed-term training appointments*", locum appointments cannot be regarded as providing acceptable training.**

Immigration arrangements

52. Overseas doctors who wish to undertake postgraduate medical education in the UK do not require their employer to hold a work permit for them. Instead the doctor can enter the country under immigration arrangements commonly referred to as *permit-free training*. An overseas doctor, to qualify for *permit-free training*, must satisfy the immigration authorities that he/she:

- intends to undergo postgraduate training in, or attached to, a hospital; and
- is registered, or is eligible to apply for registration with the General Medical Council; and
- intends to leave the United Kingdom on completion of his/her training period.

53. The *permit-free training* period is granted initially for a period of 12 months. However, the doctor may apply to the Home Office for an extension of stay provided that he continues to satisfy the requirements outlined above. Under the Immigration Rules the maximum period, in aggregate, cannot exceed four years. Limited extensions to this period of one or, very occasionally, two years may be granted exceptionally by the Home Office, outside the Immigration Rules. The principal source of advice to the Home Office in taking such decisions is the regional postgraduate dean. The deans are working to develop a consistent approach to responding to requests from overseas doctors and from the Home Office. It is intended to review the operation of these arrangements within the next two years.

54. The implementation of the *Calman Report* will see the introduction of planned and structured specialist training for both *GPT/BST* and *HST*. A complete period of specialist training will take an average **minimum** time across all specialties of about

seven years. This period may, however, be longer depending on individual progress, previous training and the duration of the training programme defined by the relevant Royal College.

h **The Working Group recommends that consideration be given to reviewing the immigration arrangements for overseas doctors (including the provision for discretionary extension of *permit-free training* status) taking account of the changes in training arrangements proposed in the *Calman Report* and in this Report.**

Registration arrangements

55. The GMC propose, subject to an amendment to the 1983 Medical Act, to replace the current dual system of *limited* and *full registration* for overseas (non-EEA) qualified doctors with a single form of *"training registration"*. Under the proposal overseas doctors would cease to be able to obtain immediate *full registration* on the basis of designated qualifications. *Training registration* would be similar to *limited registration* in that doctors would be required to work under the supervision of a fully registered medical practitioner and doctors would be eligible to proceed to full registration on demonstrating to the GMC's satisfaction that they had met the necessary standard. It is also proposed that there would be a provision that the period of *training registration* should not be less than five years and in addition, that the period could be increased, following consultation with interested parties, if educational requirements changed. These proposals would simplify the arrangements for registration with the GMC.

Implications arising from the introduction of EC Directive 93/16/EEC[12]

56. One of the recommendations of the *Calman Report* is:

> " *... that the UK Certificate of Completion of Specialist Training (CCST), be awarded by the GMC on advice from the relevant Medical Royal College that the doctor has satisfactorily completed specialist training, based on assessment of competence, to a standard compatible with independent practice and eligibility for consideration for appointment to a consultant post.* "

57. Although the above recommendation is based on the requirements of the European Directive concerning the specialist training of EEA doctors, a key question is whether overseas doctors could or should be awarded a CCST.

58. Three concerns have been identified:

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[12] Council Directive 93/16/EEC of 5 April 1993 - to facilitate the free movement of doctors through the mutual recognition of their diplomas, certificates and other evidence of formal qualifications. Official Journal of the European Communities, Vol. 36, July 1993.

- specialist training is defined in the *Calman Report* as "the whole period of training starting with full registration and extending until the award of a CCST." This appears to rule out the award of the CCST to most overseas doctors as they would normally have limited registration for at least part of any specialist training undertaken in the UK;

- Article 24 of 93/16/EEC requires that anyone undertaking specialist training leading to the award of a CCST must have obtained a recognised EEA primary medical qualification as specified in Article 23 of the same Directive (the majority of overseas doctors coming to the UK for specialist medical training would not hold an EEA primary medical qualification); and

- whether a period of specialist medical training undertaken overseas could be recognised by Royal Colleges in their advice to the GMC (and indeed by the UK competent authority under the Directive) that a doctor had satisfactorily completed a specialist training programme for the award of a CCST. Difficulties could arise for Royal Colleges if they were required to determine the standards and quality of part or all of the period of specialist training that a doctor had received abroad, especially where there were no means of attesting to the quality of the training.

59. The following observations are conditioned by legal advice:

i. eligibility for the award of a CCST should be determined solely in relation to a doctor's specialist training regardless of whether this was undertaken whilst the doctor held full or limited registration;

ii. doctors with non-EEA primary medical qualifications who are registered with the GMC, and therefore eligible to practise in the UK, are also eligible to embark upon training for, and to be awarded, a UK CCST. A CCST awarded to such doctors must, to be open and transparent to member states within the EEA, indicate (for all doctors, including those with EEA primary medical qualifications who are awarded a CCST) where the primary qualification was obtained; and

iii. subject to the above sub-paragraph, where a doctor has undertaken a small part, for example six months to a year of a specialist training programme in a non-EEA country this may, at the discretion of the relevant Royal College or Faculty, count towards the completion of a specialist training programme and hence, at the discretion of the GMC, also count towards the award of a CCST. The essential element is that the issuing member state must have control over the quality of the training. It is only then that the assurance that the training complies with the Directive can be given. Where a significant part of specialist training, for example the whole of *GPT/BST* **or** more than one year of a higher specialist training programme, is undertaken in a non-EEA country, that may also, at the discretion of the relevant Royal College and the GMC, count towards the award of a CCST but the CCST must indicate the duration of the specialist training undertaken overseas.

iv. the certificates awarded in ii and iii above would not automatically benefit from the mutual recognition arrangements under the Directive. An indication on the CCST of a non-EEA primary medical qualification and/or that a part of the specialist training had been undertaken overseas, would, however, enable other member states to decide for themselves what recognition, if any, to give to a CCST in such circumstances.

60. It is clear that most overseas doctors want to be trained to the same standard as UK doctors and to be able to demonstrate this through the qualifications they gain. Many want internationally recognised diplomas such as the CCST, or Royal College diplomas, which are the same as those taken by UK doctors. Many overseas doctors are also concerned that they receive formal recognition of their UK training experience since this is essential to advance their career on their return home.

61. Equally, it is evident that a large number of overseas doctors would not expect to achieve a CCST and it is important that doctors should not be "forced" into training aimed solely at achieving a CCST if that is not their aim.

62. Without training of the same quality and similar content for both UK/EEA and overseas doctors there will be double standards in the training system. This could lead to a deterioration in the quality of training and of patient care. In addition, even if these difficulties could be overcome, it would not be possible to award CCSTs to overseas doctors if they did not satisfy the same or equivalent entry criteria to *HST* as UK/EEA doctors.

63. A large proportion of overseas doctors will not attain a CCST either because of their limited time in the UK or simply because this is not their goal. The existing *permit-free* period, if used appropriately by overseas doctors can, nevertheless, provide for a five year *HST* programme in the UK and may lead to a College specialist diploma.

i **The Working Group notes that overseas doctors, who meet the necessary requirements and have successfully completed a specialist training programme, may be eligible for the award of a CCST by the GMC on the advice of the relevant Royal College or Faculty. It recommends that the advice of Royal Colleges and Faculties to the GMC on a doctor's training and competence should take account of training experience gained abroad, where the quality of such training can be confirmed.**

Coordinating the training arrangements for overseas doctors

64. It is important that all concerned with training arrangements for overseas doctors - Royal Colleges, the GMC, postgraduate deans, those responsible for supervising training, and employing authorities - work together. Where a doctor is sponsored a joint approach to planning training by both the relevant Royal College and postgraduate dean is important, bearing in mind that the dean is responsible for the management and purchasing of training, and monitoring its delivery.

65. Royal Colleges have particular responsibility for assuring the standard and determining the content of training programmes in which overseas doctors will participate. Under the present sponsorship arrangements they facilitate the selection and recruitment of overseas doctors, may assess their experience prior to entering training and take a leading role in assessing their progress thereafter.

66. Where there are no sponsorship arrangements the postgraduate dean must assume primary responsibility for the arrangements for training overseas doctors. The dean's role is also important since he or she is the principal and authoritative source of advice on postgraduate training to the Home Office for requests to extend the *permit-free training period*. The dean will also have responsibility for the numbering system which is proposed *(see paras 43 and 44)*.

67. Delivery of effective training to overseas doctors within or associated with the training programmes provided for UK doctors is demanding. The challenge can only be met if there is an effective partnership between all those concerned, whether at national or local level.

68. Overseas doctors have cultural backgrounds and training needs which are different from UK/EEA doctors. While some enjoy the support of a Royal College, through sponsorship, many do not. Postgraduate deans should identify a member of staff who could assume responsibility or take a special interest in issues of relevance to overseas doctors, monitor their progress, advise on their individual training needs and liaise with those who have particular responsibility for supervising their training.

j The Working Group recommends that:

i the arrangements for delivering training to overseas doctors be coordinated, monitored and evaluated and that the various parties concerned work in partnership; and

ii postgraduate deans should identify a member of staff: to assume responsibility or take a special interest in issues of relevance to overseas doctors; to monitor their progress, to advise on their individual training needs; and to liaise with those who have particular responsibility for supervising their training.

Arrangements for sponsorship including the Overseas Doctors Training Scheme

69. The recommendations on common entry *(see paras 35 - 42)* have implications for the arrangements whereby overseas doctors can enter training in the UK under sponsorship arrangements. The main features of sponsorship schemes which account for the majority of sponsored doctors are:

- exemption from the PLAB test;
- advice and support from the sponsoring organisation;

- guaranteed entry to training posts; and

- assessment of the quality of the sponsored doctor.

70. One of the main sponsorship schemes is the Overseas Doctors Training Scheme (ODTS). This is administered by a number of Royal Colleges and was introduced following changes in Immigration Rules in 1985 to facilitate the entry of overseas doctors to the UK for training. The Departments of Health provide funding on a "pump-priming" basis to the ODTS and presently meet 75% of the total costs of the schemes, with Colleges meeting the remainder. The total estimated cost of the ODTS in England in 1993/94 was £411,000.

71. The ODTS plays an important part in the current structure of postgraduate training for overseas doctors but only a minority of such doctors are on the Scheme. Of the 2,539 doctors granted *limited registration* for the first time in the year ending 1993, approximately 460 were granted exemption from PLAB through gaining a place on a College ODTS. Another major source of sponsored doctors are the double sponsorship arrangements whereby a doctor is sponsored by an individual consultant in the UK and a consultant in their home country who is known to the UK sponsor. In 1993 this category accounted for approximately 700 of the new grants of *limited registration* through exemption from PLAB test. Other sponsorship schemes administered by, for example, the British Council and the World Health Organisation, accounted for approximately a further 170 new sponsored doctors per annum.

72. From 1 April 1994, restricted exemption from the PLAB test has been limited to trainees recruited through the Royal Colleges either via the ODTS or double-sponsorship arrangements. In effect this will mean that double sponsorship arrangements and the standards of the applicants will be "vetted" by the Royal Colleges.

73. There is anecdotal evidence to suggest that while many placements under the ODTS have been successful others have either not fulfilled expectations or could be regarded as indifferent. The value of sponsorship arrangements in recruiting the more able doctor and in tailoring programmes to meet their particular requirements is acknowledged. However, given the radical changes to training patterns and to entry requirements to training programmes that are being introduced, and the Working Group's recommendations about the assessment of English language and clinical competence, certain aspects of the current sponsorship arrangements may no longer be appropriate. There is merit in reviewing sponsorship arrangements, including the ODTS.

k **The Working Group recommends, in the light of proposed changes to the training arrangements within the United Kingdom and its recommendation requiring demonstration of a satisfactory standard of English and clinical competence, that the arrangements for sponsoring overseas doctors for training in the UK, including the ODTS, should be reviewed by the Health Departments.**

Annex I

MEMBERSHIP OF THE WORKING GROUP

Chairman

Dr K Calman, Chief Medical Officer, Department of Health

Members

Dr A Admani, Overseas Doctors Association
Mrs M Anderson, Regional Medical Manpower Officer, Anglia and Oxford RHA
Dr J Biggs, Regional Postgraduate Dean
Dr E Borman, Chairperson, Junior Doctors Committee*
Professor Sir Norman Browse, President, Royal College of Surgeons*
Dr F Caldicott, President, Royal College of Psychiatrists*
Miss C Doig, Chairman, GMC Overseas Committee
Mr A Ghose, Overseas Doctors' Association
Mr M Goldman, Medical Director, Birmingham Heartlands Hospital NHS Trust
Mr J Hallett, Chairman, Central Manpower Committee*
Dr R Hangartner, NHS Executive HQ (Deputy Chairman)
Mr B Hopkinson, Central Consultants and Specialists Committee*
Mr D Jackson, Chief Executive, Bradford Hospitals NHS Trust
Mr Paddy Ross, Chairman, Joint Consultants Committee* #
Dr A Scotland, Regional Medical Officer, North Thames RHA

* - JCC nominees
# - retired 14 June 1994

Observers attending

Mr F Brewis, Scottish Office Home and Health Department
Dr J Acton, DHSS Northern Ireland
Mr H Young, Welsh Office

Secretariat provided by the NHS Executive

Dr R Cairncross
Mr G Durling
Mr R Haugh
Miss L Hawksworth

Annex II

GLOSSARY

Permit-free Training

Overseas doctors who undertake postgraduate training in the hospital service and who intend to leave the UK on completion of training are able to enter under *"permit-free"* training arrangements. Extensions to the normal four year period may be allowed by the Home Office, exceptionally outside the Immigration Rules.

Regional postgraduate deans are recognised as the principal and authoritative source of advice to the Home Office on whether applications to remain beyond the four year maximum period are justified by a genuine requirement to continue or complete postgraduate training. Deans provide advice on the following points:

i) whether the applicant is engaged in training leading to a specific goal;

ii) whether the applicant has made reasonable progress in training so far;

iii) how much longer the training will take; and

iv) whether the applicant has a reasonable chance of successfully achieving the specific training goal.

Professional and Linguistic Assessments Board (PLAB) Test

The General Medical Council is not prepared to regard any doctor as possessing the professional knowledge, skill and experience and proficiency in English language necessary for limited registration unless they have been passed or been exempted from the PLAB test. The test assesses suitability to undertake safely hospital employment at SHO level.

Visitors

Doctors with the immigration status of visitors are prohibited from taking employment as a doctor or dentist (or in any other capacity). This includes those who enter the United Kingdom in order to take the PLAB test; but an overseas doctor or dentist with visitor status may hold an unpaid clinical attachment for short periods.

NHS
Executive
Headquarters
Department of Health
Quarry House
Quarry Hill
Leeds LS2 7UE
Tel 0113 254 500

To: See Distribution List

EL(95)62
18 May 1995

Dear Colleague

HOSPITAL DOCTORS: TRAINING FOR THE FUTURE - Supplementary Reports on General Practice, Overseas Doctors and Academic and Research Medicine

1. The Working Group Report *Hospital Doctors: Training for the Future* (the "Calman Report") highlighted the need for further consideration to be given to the needs of three important groups of doctors: those training in general practice, overseas doctors and those in academic and research medicine. Therefore, three working groups were established to consider how implementation of the Calman Report would affect their training and to make recommendations.

2. I am now pleased to enclose a copy of the reports of the three working groups. These are being issued for consultation before decisions are made on their recommendations. Several recommendations in the overseas doctors report and the general practice report require action to be taken in the short term whereas others will need to be addressed in the longer term. As a guide, each recommendation in these two reports has been marked appropriately.

3. These reports provide an important contribution towards the implementation of the Calman Report. In particular they will help medical Royal Colleges to complete their work on the curricula for higher specialist training and will assist deans of postgraduate medicine to complete planning for and to commission structured training programmes in the new Specialist Registrar grade, the educational framework for which was set out in the report of the unified training grade working party EL(95)2.

4. In view of the complexity of some of the issues and the implications of some of the recommendations it is important that there should be wide and thorough consultation on these reports. The bodies and individuals from whom we are seeking comments are listed in full in the annex to this letter. Please send comments by Friday 18 August 1995 to Lesley Hawksworth, HCD-METS(E)2, Room 2W37, at the address above.

Yours sincerely

Graham Winyard

Dr Graham Winyard
Medical Director
NHS Executive

This letter will be cancelled on 31 March 1996

Medical Protection Society
Medical Royal Colleges and their Faculties
Medical Defence Union
Medical Practices Committee
National Association of GP Tutors
National Association of Health Authorities and Trusts (NAHAT)
National Association of Clinical Tutors (NACT)
NHS Trust Federation
NHS Trust Chief Executives
NHS District General Managers
NHS Unit General Managers
NHS Special Health Authority Chief Executives
Northern Ireland DHSS
Office of Fair Trading
Overseas Doctors' Association
Patients' Forum
PPP
Public Health Medicine Consultative Committee
Regional Directors
Regional Directors of Public Health
Regional Medical Management and Personnel Group
Regional Office E&T Leads
Regional Postgraduate Deans
Royal College of Nursing of the United Kingdom
Scottish Office
Standing Committee on Postgraduate Medical & Dental Education (SCOPME)
UK Central Council for Nursing, Midwifery and Health Visiting
UK Conference of Regional Advisers in General Practice
UK Conference of Medical Royal Colleges and their Faculties
UK Conference of Postgraduate Deans
Welsh Office
WPA

HOSPITAL DOCTORS : TRAINING FOR THE FUTURE

The Report of the Working Group on Specialist Medical Training

A Supplementary Report by the Working Group Commissioned to Consider the Implications for Academic and Research Medicine Arising from the Principal Report

March 1995

CONTENTS

Summary of Recommendations

Recommendation a: *Learning about research through training in research methodologies* (paras 12 - 14)

The working group recommends that:

i as a general principle, all doctors should acquire basic skills in research methodology necessary to apply research findings effectively in day to day practice;

ii training in research methodology should be an important and recognised component of all postgraduate training programmes and that further consideration by those responsible for postgraduate education, training and research be given to establishing how this might be achieved;

iii opportunities for training in research methodology should be identified during the period of *general professional/basic specialist* and *higher specialist training*; and

iv ability in interpreting and applying research findings and knowledge of research methodologies should be considered when assessing trainees for the award of a Certificate of Completion of Specialist Training (CCST).

Recommendation b: *The timing and duration of training and experience in research* (paras 16 - 22)

The working group recommends that:

i doctors should be encouraged to undertake research during the period of specialist training;

ii the duration and timing of research training, or for gaining experience of research, should be as flexible as possible to meet individual doctors' needs, be compatible with planned training programmes and enable exit from and re-entry to the programmes as required;

iii all doctors undertaking research during the period of specialist training, including those who wish to pursue a more prolonged research commitment, should obtain appropriate career guidance. In some cases this might be co-ordinated by the postgraduate dean using his or her academic contacts. However, circumstances vary and those contemplating more prolonged periods of research training will require extensive contacts with potential supervisors and host academic institutions.

Recommendation c: *The arrangements for clinical and research training* (paras 23 - 24)

The working group recommends that:

i in the context of the overall assessment leading to the award of a CCST Royal Colleges should determine what kind of report on performance during the research period is appropriate; and

ii procedures introduced should be sufficiently flexible to allow for and recognise *ad personam* training arrangements and for part-time as well as full-time training.

Recommendation d: *Supervision of research experience* (para 25)

The working group recommends that further work is undertaken by Royal Colleges, universities and postgraduate deans on appropriate methods of supervising research training which would meet requirements identified by the Royal Colleges. There should be a designated research supervisor who could, where appropriate, be the head of the unit.

Recommendation e: *Monitoring progress of trainees undertaking research* (paras 26 - 27)

The Working Group welcomes the Report of the Academic and Research Working Party to the Joint Planning Advisory Committee recommending a national strategy to support workforce planning and postgraduate education. It recommends that any system of monitoring trainees' progress should provide for those trainees pursuing research.

Recommendation f: *Problems and disincentives: implications for academic and research medicine* (paras 28 - 31)

The Working Group recognises that the introduction of structured training, including an overall decrease in the ratio of junior doctors to consultant staff will have implications for academic departments. It recommends that the new Advisory Group on Medical Education, Training and Staffing (AGMETS) should examine the consequences for the staffing of these departments as an early priority.

Recommendation g: *The contribution of universities to specialist and research training* (para 32)

The Working Group recommends that universities, medical Royal Colleges and postgraduate deans take joint action to ensure optimum arrangements for the delivery of postgraduate training.

Introduction

1. The Report of the Working Group on Specialist Medical Training (*the Calman Report*)[1] recognised that further consideration should be given to the role of and opportunities for research during specialist training, and to the particular requirements of doctors pursuing a career in academic medicine. It was acknowledged *in the Calman Report* that, in seeking to identify minimum periods for planned and structured training, opportunities for research were not ordinarily included; furthermore, the implications of the Report's recommendations on the current practice of movement between clinical training posts and academic or research posts had not been addressed.

2. A Working Group was, therefore, convened by the Chief Medical Officer specifically to:

   - identify issues relevant to academic and research medicine which may arise from implementation of the *Calman Report*;
   - explore implications arising from the Report's recommendations;
   - to make recommendations where possible, and to report.

Background

3. To fulfil the recommendations of the *Calman Report* effective management of the training experience is essential. The Report recommends that this should be achieved by introducing programmes which enable training to be better structured and planned and the progress of doctors to be effectively supervised and monitored. A further important recommendation is the introduction of a new "unified training grade"[2] which will result in two training grades within the period of specialist training[3]: the Senior House Officer grade which will provide *general professional/basic specialist training* (*GPT/BST*); and a unified training grade in which *higher specialist training* (*HST*) can be pursued. Royal Colleges and their Faculties are to specify the curricular requirements for planned specialist training programmes and, at the successful

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1 "Hospital Doctors : Training for the Future", The Report of the Working Group on Specialist Medical Training, Department of Health, 1993.

2 The name of the new grade recommended by the Unified Training Grade Working Party is "Specialist Registrar Grade".

3 The period of "specialist training" for the purposes of the EC Directive 93/16/EEC applies to the whole of the period of training following full registration and lasts until the award of a UK CCST (the Certificate of Completion of Specialist Training).

conclusion of training, it is recommended that the General Medical Council (GMC) awards individual doctors a Certificate of Completion of Specialist Training (CCST) on the advice of the relevant Royal College or Faculty. A doctor holding such a certificate would be judged to have reached a standard compatible with independent practice and would be eligible for consideration for appointment to a consultant post in the specialty concerned.

4. The award of the CCST will depend upon satisfactory completion of a training programme and of a curriculum specified by the appropriate Royal College or Faculty, which may include recognition of training undertaken outside an approved training programme or mainstream NHS training posts. It is recognised that the arrangements proposed must accommodate the needs of doctors pursuing careers in academic or research medicine and provide opportunities for doctors intent on a career in clinical practice both to pursue research and to acquire a training in research.

5. The *Calman Report* identified the importance of flexibility in accommodating the training requirements of different specialties and the disparate needs of individual trainees. A particular challenge is how best to provide for the different requirements of clinical and research training.

6. The *Culyer Report*[4] has drawn attention to the need to develop a human resource strategy for research and development in the NHS and to the importance of the skills required to implement research findings which need to be available to managers as well as health professionals. This Report, however, does not aim to present a human resource strategy to meet the requirements of academic or research medicine. It seeks only to address those issues related to academic and research medicine, which may follow from taking forward the recommendations of the *Calman Report* (in particular the introduction of planned or structured training programmes during the phase of higher specialist training), and their impact on two cohorts of doctor: those intent on a career in clinical specialist practice for whom a period of research experience and training may be desirable; and those intent on a career in academic or research medicine for whom opportunities to pursue clinical specialist training are often essential.

7. Recent guidance sets out the arrangements for research and development in the NHS[5] in England. The strategy will address the retention and development of research workers and teams as well as their basic training.

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[4] Supporting Research and Development in the NHS, A Report to the Minister for Health by a Research and Development Task Force chaired by Professor Anthony Culyer, London HMSO, 1994.

[5] Research and Development in the New NHS: Functions and Responsibilities, NHS Executive, November 1994.

Key Issues Concerning Specialist Training Relevant to Academic and Research Medicine

8. This Report addresses a spectrum of research activity that impinges on the specialist training of all doctors, for example:

- those pursuing a clinical career who must acquire an understanding of research methodology, the skills of evaluation and critical thought and the ability to apply these to clinical practice - they may attain this goal by participating in short courses;

- those pursuing a clinical career who wish to undertake a research project, ordinarily the equivalent of one year's work and leading perhaps to a diploma;

- those who will elect to pursue a longer period in research, expect to obtain a PhD or other higher degree but who may ultimately elect primarily to pursue a clinical career; and

- those who intend to pursue a career in academic and research medicine which will require them to complete training in clinical medicine in order to pursue their chosen career.

The interface between training for specialist practice and for academic and research medicine

9. Specialist medicine, whether pursued by NHS consultants or clinical academics, is practised in an environment in which rapid change brought about by advances in bio-medical science and technology is the norm. A culture supportive of research needs to be established throughout the continuum of medical education. Within the diverse career paths available in the NHS a broad division can be made between the majority who seek a predominantly clinical career within the NHS and a significant minority who plan a career in academic or research medicine which combines research and teaching with a substantial component of clinical service. For both groups acquisition of the skills necessary to undertake research and evaluate research findings is of great importance, but the degree of expertise expected of those pursuing a research career ordinarily requires a longer and more complex training.

10. Clinical academics (Professors, Readers, Senior Lecturers, Clinical Research Fellows etc) form a substantial proportion of the clinical staff in the main teaching hospitals and are often at the forefront of new developments in medical care. Many of the profession's leaders are drawn from the clinical academic community. Just as training for specialist medicine has become more structured and demanding the same is true of training for a career in clinical research. Many clinical academics now spend three years in research training in addition to the period of training required in their clinical specialty. The shortened period of specialist training now planned means that most clinical academics will continue to require a longer overall period of clinical and research training compared with doctors who are planning an NHS

specialist career.

11. It is in the interests of the NHS as a whole as well as the universities and medical research sponsoring bodies that those who opt for a clinical academic career should not feel disadvantaged by their longer period of training. Careful planning of the career path, particularly aimed to ensure smooth re-entry into clinical training after a full time period of research training, should minimise problems; this might involve the early or prior identification of a suitable post in a training programme into which such doctors could move once their research training had been completed. Close integration of the academic, research and service aspects of training programs with those of service should facilitate flexibility both for those wishing to stay in academic medicine and for those wishing to return to NHS clinical practice. The position of clinicians at present undertaking a period of research training (eg MRC or AMRC three year training fellowships) between registrar and senior registrar posts must not be overlooked during the period of transition to the unified training grade.

Learning about research through training in research methodologies

12. If doctors have neither the opportunity nor the wish to pursue training in research nor to gain experience of research, then there is a case for them at least to learn how to interpret and apply research findings. An understanding of the fundamentals of clinical research is vital for effective clinical practice, if only to ensure that the hard-pressed clinician is able to evaluate and apply the results of research as they become available. To enable such doctors to appreciate the culture of research, question received wisdom and to understand the uncertainty of data, it is desirable that they acquire skills in interpreting and applying research findings. This should equip them to evaluate and incorporate major developments and new knowledge into their own clinical practice and to hone and develop problem-solving skills. Many of these skills are invaluable in efforts to improve patient care. Learning to apply research knowledge should, therefore, be part of the training of all doctors. It is already a key element of the undergraduate curriculum and should be built upon during postgraduate training. Further work is needed by those responsible for postgraduate education, training and research to establish how this might be accomplished.

13. Skills in interpreting and applying research findings, along with the necessary knowledge and experience in research methodologies, could be gained by undertaking project work or through a taught course. They could be provided for within the curricula for structured training programmes currently being developed by the Royal Colleges and their Faculties and could be delivered during the periods of *GPT/BST* and *HST*. Participation in project work could supplement a taught course which could last from a few months up to one year but project work should be integrated into training programmes and be appropriately supervised and directed. The ability to apply research and the knowledge of research methodologies should be considered when assessing trainees for the award of a CCST.

14. The periods of *GPT/BST* and *HST* should be planned to provide time in which all trainees are able to develop their skills in research methodology. The UK Conference

of medical Royal Colleges and the GMC are reviewing the period of *GPT/BST* and they should consider recommending training in research methodologies. Resources required to fulfil such a training goal, within those available to sustain current training programmes, should be explored.

a **The working group recommends that:**

i **as a general principle, all doctors should acquire basic skills in research methodology necessary to apply research findings effectively in day-to-day practice;**

ii **training in research methodology should be an important and recognised component of all postgraduate training programmes and that further consideration by those responsible for postgraduate education, training and research be given to establishing how this might be achieved;**

iii **opportunities for training in research methodology should be identified during the periods of *general professional/basic specialist* and *higher specialist training*; and**

iv **ability in interpreting and applying research findings and knowledge of research methodologies should be considered when assessing trainees for the award of a Certificate of Completion of Specialist Training (CCST).**

Learning about research through training and experience gained in research

15. For most doctors opportunities to gain experience of research are desirable if not essential components of their training. As medical Royal Colleges introduce new curricula for programmes of higher specialist training, it is already evident that most, if not all, are recommending a year in research for all their trainees. However, while experience of research has enriched and advanced the career of many trainees, there is some evidence to suggest that not all such experience has proved valuable or indeed attractive to trainees. In some cases the research has appeared irrelevant to the interests and career aspirations of the doctor involved; in others the quality of the results has been disappointing, undermining its value educationally as well as its contribution to medical knowledge. This underlines the need for all such research to be properly planned and supervised.

The timing and duration of training and experience in research

16. To ensure that training in research, together with experience of research undertaken during specialist training, relates effectively to postgraduate specialist training programmes, further thought needs to be given to a range of practical considerations including the stages during training at which these could effectively occur:

- whether research should be integrated into all or just certain specialty training

programmes;

- whether or not it should be an essential component of training for all doctors;

- whether it should precede, run in concert with or follow higher specialist training; and

- whether a period of one year, as is often recommended, is optimal for doctors whose planned career is as an NHS consultant.

17. Following implementation of the *Calman Report* there will be a range of options for the timing of research undertaken during specialist training; it might be completed before entry to a higher specialist training programme is sought; pursued during higher specialist training (whether as part of or outside a formal or approved training programme); or as a combination of these. There will also be opportunities to carry out research after the completion of specialist training but before a consultant post is taken up.

18. The arrangements for specialist training must be flexible and meet the needs of doctors wishing to take on a more prolonged research commitment, whether or not they wish to pursue a career in academic and research medicine. Those undertaking or planning to undertake research, which is not recognised as an integral part of higher specialist training programmes by the relevant Royal College or Faculty and which would extend the duration of their training, should receive appropriate career guidance from those responsible for supervising their research, the funding bodies (where relevant), college regional advisers and the postgraduate dean. Information about recognition of research experience should be sought from the relevant Royal College by the doctor prospectively. However, most Royal Colleges have indicated that the maximum period of research that they will accept as an "educational credit" towards the award of a CCST is one year. There may well be opportunities to integrate a chosen research project within a carefully planned specialist training programme in such a way as to minimise the additional time required before obtaining a CCST.

19. The timing and duration of training in and experience of research is a matter for the individual and his or her advisers. Its relationship to the new structured training programmes is a matter for the Royal Colleges and their Faculties to determine. However the range and diversity of ways in which such research could be organised (including, for example, a project extending over several years interdigitated into clinical training in such a way as to enable a doctor in specialist training to undertake a substantial research project and obtain a CCST without a significant increase in the overall duration of training) means that it needs to be carefully planned for the individual trainee to obtain the best result. Such careful planning would be facilitated if Royal Colleges were to adopt a flexible approach wherever possible.

20 A particular need of a clinical academic may be to undertake a period of research in another centre which may be in a different NHS region. Because of increasing international competition in medical research such periods are longer than hitherto,

often taking the form of a postdoctoral fellowship. Desirable arrangements already being instituted include the interdigitation of periods of clinical and research work allowing recipients of longer term fellowships (such as MRC Clinician-Scientists) to complete specialist training and be granted honorary consultant status. It is important that regionally-based training schemes should not impede the ability of gifted young doctors to secure training in the most appropriate centre. The National Training Number *(NTN)* should be implemented in a way which should not impede movement between regions.

21. Research is not necessarily specialty-specific and may for some be a sensible option to pursue before entry to an *HST* programme. However, as a consequence of competitive entry to *HST* programmes, trainees may understandably perceive that they will improve their chances of appointment to the more popular programmes were they to complete research before seeking appointment. A research diploma should not become a pre-requisite for entry to *HST* programmes or come to represent an additional obligatory hurdle in career progression for future NHS consultants. Development of linkages between research and clinical practice may be easier to achieve if the period of research training is intercalated with the *HST*.

22. Effective and coordinated career guidance from those supervising the programme of higher specialist training and the period of research training will be crucial if trainees are to secure the maximum benefit from it. It is important that trainees maintain contact with those responsible for supervising and planning specialist training during the time they are pursuing research. Postgraduate Deans will be required to monitor all trainees holding *NTNs* and will therefore provide a point of contact.

b The working group recommends that:

i doctors should be encouraged to undertake research during the period of specialist training;

ii the duration and timing of research training, or for gaining experience of research, should be as flexible as possible to meet individual doctors' needs, be compatible with planned training programmes and enable exit from and re-entry to the programmes as required;

iii all doctors undertaking research during the period of specialist training, including those who wish to pursue a more prolonged research commitment, should obtain appropriate career guidance. In some cases this might be co-ordinated by the postgraduate dean using his or her academic contacts. However, circumstances vary and those contemplating more prolonged periods of research training will require extensive contacts with potential supervisors and host academic institutions.

The arrangements for clinical and research training

23. Research may be pursued in a variety of locations, sometimes geographically distinct from the location of the trainee's clinical training programme, and can be independent of, and need not relate specifically to, specialty-orientated training programmes.

24. The arrangements for pursuing research in association with specialist training need to be defined and guidelines issued so that all trainees are aware of the implications for their career plan on or before entry to the higher specialist training grade. Providing standards can be maintained, the arrangements should be sufficiently flexible to allow for those who wish to follow a *"fast track"* satisfying the minimum requirements for specialist training; therefore, there should continue to be a place for *ad personam* training arrangements, for example academic staff who are currently following an unconventional approach to higher specialist training. However, it would be unacceptable for a doctor to be awarded a CCST without having satisfactorily completed an "equivalent" specialist training programme to the standard set by the relevant Royal College or Faculty. The assessment would have to be seen to be fair, just and equitable. Royal Colleges should judge progress on an individual basis and advise the GMC. In this context the move towards competency-based assessment may be helpful as it could provide one means of assessing the acquisition of clinical skills which is independent of the route taken in acquiring them. The arrangements for research must also include provision for part-time as well as full-time training.

c **The working group recommends that:**

i **in the context of the overall assessment leading to the award of a CCST Royal Colleges should determine what kind of report on performance during the research period is appropriate; and**

ii **procedures introduced should be sufficiently flexible to allow for and recognise *ad personam* training arrangements and for part-time as well as full-time training.**

Supervision of research experience

25. All training in research must be properly supervised by experienced active researchers. Supervisors should set aside time specifically to oversee trainees' research which should be undertaken in a professional environment. The heads of units where it is undertaken should accept responsibility for the standards of research and of research training. They must also ensure that there is provision for checking and monitoring standards so that postgraduate trainees will find the time spent in research both productive and rewarding.

d **The working group recommends that further work is undertaken by Royal Colleges, universities and postgraduate deans on appropriate methods of supervising research training which would meet requirements identified by the Royal Colleges. There should be a designated research supervisor who could,**

where appropriate, be the head of the unit.

Monitoring progress of trainees undertaking research

26. The Report of the Academic and Research Working Party to the Joint Planning Advisory Committee[6] (JPAC) has been received by JPAC and its recommendations attached at *Annex II* accepted. The Report proposed an information strategy based on national training numbers to support manpower planning and postgraduate education. Its principal features are:

- a personal, regional and specialty-specific national training number *(NTN)* allocated to individual trainees and linked to specialty-determined national quotas;
- a national programme or post number *(NPN)*, identifying the location and purpose of the training programme or post.
- central co-ordination and monitoring;
- flexibility (in particular the ability to accommodate those holding academic or research appointments); and
- procedures which ensure that the progress of all trainees can be monitored.

27. Agreement to introduce this scheme has been achieved in principle[7], although detailed arrangements have still to be confirmed. An implementation steering committee has reported on the first phase of implementation (summary of recommendations is at *Annex III*). In practice it is proposed that an *NTN* will only be required for the period of higher specialist training and would ordinarily be awarded to any trainee holding an honorary or substantive appointment in a rotational training programme in the proposed unified training grade. Once awarded, the *NTN* would be held for the period of higher specialist training leading to the award of a CCST and would include trainees undertaking research as part of a recognised training programme. In addition there is provision for the *NTN* to be retained should a trainee wish to undertake a period of research outside the scope of a structured training programme or indeed any other activity - including working overseas - not contributing to the attainment of a CCST. Workforce planning arrangements linked to the award of the *NTN* are being developed to take account of the requirements of research trainees within the proposed unified training grade. Doctors undertaking research who do not wish to pursue clinical specialist training leading to the award

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[6] Numbering Trainees, Programmes and Posts: A National Strategy To Support Manpower Planning, Postgraduate Education and Research within the National Health Service.

[7] At this stage the proposed numbering arrangements apply only to England and Wales. Similar systems are being developed in Scotland and Northern Ireland. It is intended that these will harmonise with those in England and Wales.

of a CCST will not require an *NTN* or to hold an educationally approved training appointment in the proposed unified training grade.

e **The Working Group welcomes the Report of the Academic and Research Working Party to the Joint Planning Advisory Committee recommending a national strategy to support workforce planning and postgraduate education. It recommends that any system of monitoring trainees' progress should provide for those trainees pursuing research.**

Problems and disincentives: implications for academic and research medicine

28. A career in academic medicine provides an intellectually rewarding opportunity to advance medical knowledge as well as to teach the next generation of doctors. However, the career path for clinical academics is generally less certain than for NHS consultants. Intense competition for research grants, which may provide personal salary support, as well as technical assistance and consumables means greater insecurity, particular during the period a young clinical researcher is seeking to establish an independent reputation. Retaining flexibility between university and NHS posts is essential.

29. There are concerns that, with the introduction of formal specialist training programmes, the recruitment of clinical scientists will diminish since:

- shorter, planned training programmes may mean that few trainees are exposed or attracted to clinical science;
- rotational programmes may emphasise training in district general hospitals with, as a consequence, less time spent in academic centres;
- gaining release from a training programme to pursue research may prove difficult if the service contribution made by the trainee is compromised; and
- pressure to undertake research before entry to higher specialist training may increase - perhaps not the optimum time for most trainees.

30. At present academic units generally have higher staffing levels of trainee medical staff than comparable NHS units, particularly at senior registrar level. The proposed changes in the length of specialist training recommended in the *Calman Report*[8] will in the longer term lead to an increase in the ratio of consultant to junior staff with, in certain specialties, a reduction in the number of junior staff. Such changes could diminish university influence on medical practice if they are not reflected in similar staffing changes in academic departments.

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[8] It is envisaged that the present duration of specialist training (averaged across all hospital specialties) of twelve years would fall to an average minimum of seven years.

31. There is concern that service demands on academic departments may be increasing, perhaps partly as a consequence of the NHS reforms. Changes in the ratio of senior to junior staff, whether or not accompanied by a reduction in junior staff in certain specialties, will also affect academic departments as supervisors will have to undertake work previously done by trainees. Without enhanced funding for senior lecturer posts, academic units will not be able to adjust their staffing to reflect moves towards expanding the NHS consultant grade and the delivery of a consultant-based service. It is in the interest of the health service to maintain a strong commitment to academic facilities and, therefore, the increase in consultant numbers identified in the *Calman Report* should be extended to the academic establishment through the conversion of some NHS senior registrar posts, which are at present held on academic units, into senior lecturer posts.

f **The Working Group recognises that the introduction of structured training, including an overall decrease in the ratio of junior doctors to consultant staff will have implications for academic departments. It recommends that the new Advisory Group on Medical Education, Training and Staffing (AGMETS) should examine the consequences for the staffing of these departments as an early priority.**

The contribution of universities to specialist and research training

32. The medical Royal Colleges have the primary role in determining standards and setting curricula for postgraduate education and training. Delivery of the programmes of education at regional level depends on complex arrangements within NHS Trusts managed by the postgraduate dean in association with the regional college advisers, the universities' medical schools and Trust medical staff. The universities have much to contribute to specialist training particularly in the development of specific courses and programmes. Much expertise exists in the universities which is available and efforts should be made to incorporate this expertise in the overall process. Collaboration between the Royal Colleges and medical schools will become increasingly important as more structured programmes of training increasingly complement apprenticeship learning. Further, as the role for purchasing education develops the contribution that universities may make may change and develop. Maintaining close links between the postgraduate deans and the medical schools is also essential to ensure that there is a seamless continuum of education.

g **The Working Group recommends that universities, medical Royal Colleges and postgraduate deans take joint action to ensure optimum arrangements for the delivery of postgraduate training.**

Annex I

MEMBERSHIP OF THE WORKING GROUP

Chairman

Dr K Calman, Chief Medical Officer, Department of Health

Members (as at October 1993)

Professor Sir Colin Dollery - Dean, Royal Postgraduate Medical School
Professor C Easmon - Postgraduate Dean, North Thames
Professor F Harris - Dean, University of Leicester
Mrs C Ingham Clark - Junior Doctors Committee, British Medical Association
Professor P Lachmann* - President, Royal College of Pathologists
Mr Paddy Ross** - Chairman, Joint Consultants Committee
Professor Sir Leslie Turnberg - PRCP London and Chairman, Conference of Medical Royal Colleges

* Not replaced
** Replaced by Professor Sir Norman Browse

Additional Members (from January 1995)

Professor Dame June Lloyd - Association of Medical Research Charities
Dr D Evered - Medical Research Council
Dr R Hangartner - NHS Executive

Secretariat provided by the NHS Executive

Mr S Catling
Dr R Cairncross
Miss L Hawksworth

Annex II

A List Of The Principal Features Of The Report Of The Academic And Research Working Party To The Joint Planning Advisory Committee (JPAC) - "Numbering Trainees, Programmes and Posts: A National Strategy To Support Manpower Planning, Postgraduate Education And Research Within The NHS", January 1994.

PRINCIPAL FEATURES

- the Department of Health, National Health Service Executive (NHS Executive) implements policy on manpower planning, taking into account the advice of JPAC, and coordinates and monitors a national information strategy to support manpower planning and postgraduate education;

- a regional[9] and specialty-specific ***national training number (NTN)***, required by all trainees to participate in higher specialist training programmes, held for the duration of training or until it has to be relinquished, and reflecting the career which the trainee intends to pursue or the specialty in which he or she wishes to obtain a *Certificate of Completion of Specialist Training (CCST)*;

- allocation of a ***national training number (NTN)*** triggered by appointment to a higher specialist training programme by a regional appointments committee;

- participation in appointment procedures by Royal Colleges and their Faculties, NHS employing authorities, universities and regional postgraduate deans;

- flexibility in numbering arrangements to reflect trainee movement between centres in the United Kingdom and overseas and, where necessary, to change career pathway;

- specific arrangements for monitoring trainees undertaking research;

- availability of ***national training numbers (NTNs)*** coordinated and monitored by the NHS Executive through a system of regional and specialty specific quotas;

- electronic interchange of data between the NHS Executive and databases operated by regional postgraduate deans in partnership with employing authorities, and the Royal Colleges and their Faculties;

- validation of manpower information derived from ***national training and programme/post numbers*** through an annual system of recording the individual trainee's continuing requirement for his/her ***national training number (NTN)***;

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[9] For an explanation of the terms "regional" and "region" as used throughout this Report please refer to *Annex I* para 2 page 25.

- a separate ***national programme/post number (NPN)***, approved and identified by Royal Colleges and regional postgraduate deans to locate the trainee and to record the current educational status of the programme or post;

- a national strategy supported by timely and authoritative intelligence provided by the NHS Executive; and

- harmonisation with other NHS information services.

Annex III

A List Of Principal Features And A Summary Of The Recommendations From The Report Of The National Training Number Implementation Steering Committee "Guidance On Introducing National Training, Post And Programme Numbers", June 1994.

PRINCIPAL FEATURES

It is suggested that the following principles should guide the way in which the NTN is set up and managed:

a The Report "Numbering Trainees, Programmes and Posts" outlines the main features of the system as central co-ordination and monitoring; flexibility (in particular the ability to accommodate higher specialist trainees holding academic and research appointments); procedures that ensure that the progress of all trainees can be monitored; and the provision of regular and validated data derived from associated database systems;

b Arrangements should be able to accommodate the outcome of the Functions and Manpower Review;

c The allocation of an NTN is triggered by the appointment of a doctor *via* an appropriately constituted appointments committee to a higher specialist training programme in the unified training grade leading to the award of a CCST.

d The NTN must only be allocated to trainees, including those in NHS Honorary posts, appointed to training programmes (or posts associated with programmes) approved by both the Royal Colleges and the PG Dean;

e NTNs should be issued, validated and managed by the Regional Postgraduate Deans. Individual trainees must be made aware of their training number by the Dean;

f The role of the NHS Executive should be to ensure that there is a workable national system compatible across the NHS and to monitor and validate as necessary;

g The structure of the NTN should ensure no ambiguity and should be fully compatible with the PG Dean's database;

h All components of the NTN should be set at entry to higher specialist training [10] and should not change unless the trainee changes specialty or elects to move to a

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[10] *For NTN purposes higher specialist training is essentially synonymous with the new unified training grade in most specialties.*

programme under another Dean [11];

SUMMARY OF RECOMMENDATIONS

a We recommend that the National Training Number should be issued by the Postgraduate Dean and should take the form:

A PG Dean identifier	/	A specialty code number	/	Individual sequence number

where

- the PG Dean identifier should comprise a mnemonic code of three letters derived from the "title" of each Dean.
- the specialty code should be the three digit specialty codes used in the annual Medical and Dental Manpower Census for those specialties in which a CCST is awarded.
- each Dean should issue a three digit (numeric) sequence code to identify the individual trainee in each specialty.

Allocation of an NTN is triggered by the appointment of a doctor to a higher specialist training programme. The individual trainee should be made aware of his/her NTN and be involved in the validation of data held by the Postgraduate Dean.

b We recommend that, subject to the outcome of the Working Group on overseas doctors set up as part of the implementation of *Hospital Doctors:Training for the Future*, there should be a separate but parallel Visitors Training Number for overseas doctors in higher specialist training. This VTN should be distinguished from the NTN by using a three digit individual national number in the range 501->999, together with the suffix /V (for visiting).

c Using the nomenclature we recommend:

NWT / 021 / 007 might be a "career" general surgeon under the North West Thames Dean, and

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[11] *Changing an NTN should not be undertaken lightly since, once relinquished, there is no automatic re-allocation just because the trainee moves to a new specialty or a new area. He/she would have to compete for a place on a new training programme and a new NTN; if the Dean had no number available in the specialty chosen the trainee would face real difficulties. This is why mobility is heavily weighted to the trainee retaining the NTN wherever he/she moves provided the parent Dean is agreeable and the trainee continues to pursue training consistent with the NTN specialty he/she holds (or otherwise seeks a break, eg for research). The NTN returns to the parent dean once it is relinquished.*

might be a "visiting" general surgeon under the NWT Dean.

d We recommend that the NHS Executive, Postgraduate Deans and Royal Colleges ensure that registration under the Data Protection Act allows them to share data for the purposes of monitoring and managing medical training.